Health Care Financing Program Statistics

The Medicare and Medicaid Data Book, 1981

Published by the Health Care Financing Administration
Office of Research and Demonstrations

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The Health Care Financing Administration was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review Organization program, and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 49 million of the nation's aged, disabled, and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

HCFA's Office of Research, Demonstrations, and Statistics (ORDS) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. ORDS also assesses the impact of HCFA programs on health care costs, program expenditures, beneficiary access to services, health care providers, and the health care industry. In addition, ORDS monitors national health care expenditures and prices and provides actuarial analyses on the costs of current HCFA programs as well as the impact of possible legislative or administrative changes in the programs.

The Medicare and Medicaid Data Book is the continuation, and expansion to include Medicare, of the annual series previously entitled ***Data on the Medicaid Program: Eligibility/Services/Expenditures.*** The purpose of this annual series is to provide a broad overview of the Medicare and Medicaid programs as well as to present basic descriptive data of use to policymakers, program managers, and other persons interested in these programs. More detailed data and information can be found in the individual Medicare and Medicaid program statistics publications series.

The Medicare and Medicaid Data Book, 1981

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This publication was prepared by the Medicaid Program Data Branch, Division of Beneficiary Studies, Office of Research, under the general direction of Judith R. Lave, Ph.D., and under the guidance of an advisory panel comprised of Allen Dobson, Ph.D., George Kowalczyk, David Gibson, Herbert A. Silverman, Ph.D., Marian Gornick, Karen O'Steen, and Charles Fisher.

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Introduction

This volume presents comprehensive data describing the Medicare and Medicaid programs. The data are intended as a resource for public officials, researchers, policy analysts, and consumers with an interest in these health programs. The material is organized into four chapters. Chapter I provides brief overviews of Medicare and Medicaid and presents information on the interaction between the programs, Federal administration of both programs, comparative program expenditures, and the relationship of Medicare and Medicaid expenditures to total health care spending.

Chapter II reports trends in the Medicare and Medicaid programs covering various facets of program development over the last ten to fifteen years. Trends are described for the number of Medicare enrollees and Medicaid recipients; Medicare and Medicaid expenditures; and the use and expenditures for hospital inpatient and physicians' services in both programs. Trend data for particular services in each program are also presented.

Chapter III describes the major characteristics of the Medicare program, supported by program statistics. Medicare eligibility, benefits, financing, and administration are outlined, for both the hospital insurance and the supplementary medical insurance programs. Data are presented on enrollment and expenditures for both the aged and disabled. Detailed information is provided on the distribution of Medicare benefits and reimbursements for various services, different categories of enrollees, and on the program's financing and administration. The chapter concludes with a description of Medicare's arrangements with Group Practice Prepayment Plans and Health Maintenance Organizations and a discussion of Medicare's statistical system.

Detailed data on the Medicaid program are reported in Chapter IV. Descriptions of Federal rules and State options are followed by information on States' provisions for eligibility and benefits. Statistical information is then presented on service use and expenditures for each State and jurisdiction. In instances where Federal and State Medicaid data were found to differ during the development of this publication, State data were incorporated into this publication. Hence, the data in this publication may differ slightly from those in other HCFA publications. The chapter concludes by describing elements of Medicaid financing and administration, including matching rates for Federal Financial Participation, recipients and expenditures under State "buy-ins" to Medicare, numbers of certified providers, adoption of management information systems, fraud and abuse, quality control error rates, and Medicaid's data system.

Appendices are included in this volume to facilitate readers' understanding of the material and to identify sources that can answer any questions that arise. Names, addresses, and phone numbers are listed for Medicare intermediaries and carriers, Medicaid single State agencies and medical assistance programs, and officials within HCFA who are responsible for different aspects of the Medicare and Medicaid programs and data related to them. A glossary and list of acronyms used in this report are also included as Appendices.

I. Introduction to Medicare and Medicaid

This chapter outlines the major characteristics of the Medicare and Medicaid programs. Information is also presented on the relationship between the two programs. Specifically, this chapter describes how Medicare and Medicaid interact in relation to persons eligible for both programs ("dual eligibles"); how the Federal government is organized to administer both programs; how much each program spends (in total and per enrollee or service recipient) in each State; and the share each program pays of the health care expenditures of persons in different age groups.[1]

A. Overview of the Medicare Program

The Medicare program covers hospital, physician and other medical services for persons aged 65 and over, disabled persons entitled to social security cash benefits for twenty-four consecutive months, and most persons with end-stage renal disease. Total Medicare expenditures were over $28 billion in fiscal year 1979.

Medicare has two complementary but distinct parts: Hospital Insurance (HI), known as Part A, and Supplementary Medical Insurance (SMI), known as Part B. The Hospital Insurance program covers 90 days of inpatient hospital care in a benefit period ("spell of illness")—which begins of hospitalization and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility (SNF) for 60 continuous days. There is no limit to the number of benefit periods an individual may use. The program also provides a one-time ("life-time") reserve of 60 days to use if a beneficiary exhausts the 90 days available in a benefit period. In addition to inpatient hospital care, the hospital insurance program covers up to 100 post-hospital days in an SNF if the beneficiary is certified to require such care. The program also covers home health agency visits.

About 95 percent of the nation's aged population is enrolled in the hospital insurance program. On July 1, 1966, when the Medicare program became operational, there were 19.1 million persons enrolled in the program. By July 1, 1980, the number of aged enrollees had increased to 25.1 million.

Nearly everyone covered by hospital insurance voluntarily enrolls in the supplementary medical insurance (SMI) program. Unlike the hospital insurance program, SMI coverage is contingent upon the payment of a monthly premium—$11 per month as of July 1981. Under "buy-in" agreements, most State Medicaid programs pay these premiums for persons who qualify for Medicaid in addition to Medicare. The SMI program provides payments for physicians as well as related services and supplies ordered by the physician. SMI also covers outpatient hospital services, rural health clinic visits, and home health visits.

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[1] The Omnibus Budget Reconciliation Act of 1981 was not finalized at the time this publication went to press. Hence, the descriptions contained in this publication do not include the revisions encompassed within this act.

Several health care services that the aged generally use on a continuing basis such as drugs, dental care, routine eye examinations, and preventive services are not covered by Medicare.[2] Long-term institutional services are not covered either.

Both the HI and SMI programs require beneficiary cost sharing. Under the hospital insurance program, the patient is required to pay an inpatient hospital deductible in each benefit period. This deductible approximates the cost of one day of hospital care. Coinsurance based on the inpatient hospital deductible is required for the 61st-90th day of inpatient hospital care (always equal to 1/4 of the deductible), for the 21st-100th day of skilled nursing facility care (1/8 of the deductible), and for the 60 lifetime reserve days for inpatient hospital care (1/2 of the deductible). The patient is also liable for the cost (or replacement) of the first three pints of blood.

Under SMI, in addition to paying a monthly premium, the beneficiary must meet a $60 deductible each year. On each claim for payment, physicians can accept or reject assignment. Acceptance of assignment means that the physician agrees to accept as full payment the amount Medicare allows for the service. The program reimburses 80 percent of allowed charges directly to the physician. Beneficiaries are liable for the remaining 20 percent (coinsurance) of allowed charges. On unassigned claims, the beneficiary is also responsible for the difference between the physician's charge and the allowed charge. Beneficiaries covered under Medicaid buy-in agreements are relieved of these cost sharing obligations.

Medicare benefits and administrative expenses are paid from two separate trust funds. The hospital insurance trust fund is financed primarily through a tax on current earnings from employment covered under the Social Security Act. The supplementary medical insurance trust fund is financed through premiums paid by or on behalf of persons enrolled in the program and by the Federal government from general revenues.

B. Overview of the Medicaid Program

Medicaid is a federally supported and State administered assistance program providing medical care for certain low income individuals and families. Medicaid accounted for over $20 billion in Federal and State expenditures in fiscal year 1979, and is the primary source of health care coverage for the poor in America. The program is designed to provide medical assistance to those groups or categories of people who are eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act; that is, Title IV-A, the program of Aid to Families with Dependent Children (AFDC), or Title XVI, the Supplemental Security Income (SSI) program for the aged, blind, and disabled. In most cases, receipt of a welfare payment under one of these programs means automatic eligibility for Medicaid.[3] In addition, States may provide Medicaid to the "medically needy," that is, to people (1) who fit into one of the categories of people covered by the cash assistance programs (aged, blind, or disabled individuals or members of families with dependent children when one parent is absent, incapacitated, or unemployed), and (2) to those who have enough income to pay for their basic living expenses (and so are not recipients of welfare), but not enough income to pay for their medical care.

Title XIX of the Social Security Act requires that every State Medicaid program offer certain basic services: inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing facility services for individuals 21 and older, home health care services for individuals eligible for skilled nursing services, physicians' services, family planning services, rural health clinic services, and early and periodic screening, diagnosis, and treatment services for individuals under 21. In addition, States may provide a number of other services if they elect to do so, including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21, physical therapy, and dental care.

Medicaid operates as a vendor payment program. Payments are made directly to providers of service for care rendered to eligible individuals. Providers must accept the Medicaid reimbursement level as payment in full. In medical institutions and intermediate care facilities, individuals are required to turn over income in excess of their personal needs and maintenance needs of their spouses to help pay for their care. States may require Medicaid recipients to pay cost sharing on services but they may not require the categorically eligible to share costs for mandatory services. As noted above, most State Medicaid programs have buy-in agreements with Medicare. Under these agreements, Medicaid assumes responsibility for the Medicare cost-sharing obligation of persons covered under both programs.

Medicaid is financed jointly with State and Federal funds. Federal contributions vary with States' per capita income and currently range from 50 percent to 77.55 percent of program medical expenditures. Administration and Medicaid Management Information System (MMIS) costs are matched at other rates. States participate in the Medicaid program at their option. All States except Arizona currently have Medicaid programs. The District of Columbia, Puerto Rico, Guam, the Northern Marianas, and the Virgin Islands also provide Medicaid coverage. States administer their Medicaid programs within broad Federal requirements and guidelines. These requirements allow States considerable discretion in determining income and other resource criteria for eligibility, covered benefits, and provider payment mechanisms.[4] As a result, the characteristics of Medicaid programs vary considerably from State to State.

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[2] Drugs and certain dental procedures are covered if provided during an authorized hospital inpatient stay.

[3] Chapter four contains a more detailed discussion of the major differences among States in the criteria used to determine program eligibility.

[4] States may also include non-categorically eligible ("State-only" or "medically indigent") persons in their medical assistance programs, but receive no Federal contributions for the costs of their care.

C. Comparative View of Medicare and Medicaid

1. Interrelated Coverage

About 12 percent of aged and disabled Medicare enrollees are also covered by State Medicaid programs. States can obtain SMI coverage for the Medicare-eligible Medicaid recipients under "buy-in" agreements with Medicare. With the "buy-in," States pay the SMI premium and take responsibility for cost sharing. When persons are eligible under both programs, Medicare makes the primary payments for services, and the Medicaid obligation is limited to the deductible and coinsurance amounts. States receive Federal matching payments for these expenditures. While States may buy into Medicare for any of their Medicaid eligibles who are also eligible for Medicare, they receive Federal matching payments on premium payments only for persons receiving cash assistance. States must pay the full cost of premium payments for other Medicaid eligibles.

If a State does not buy into SMI coverage for persons in their Medicaid program who are eligible under Medicare, it cannot receive Federal matching payments for expenditures for services that would have been covered under Medicare if there had been a buy-in arrangement. Among States and jurisdictions with Medicaid programs (all States except Arizona), forty-six States and jurisdictions have buy-in arrangements; four States and one jurisdiction do not (Alaska, Louisiana, Oregon, Wyoming, and Puerto Rico).

State Medicaid programs also provide many services for the aged and disabled that are not provided by Medicare. Services include skilled nursing facility care beyond the 100-day post-hospital benefit provided by Medicare, long-term care in intermediate care facilities, prescription drugs, eyeglasses, and hearing aids.

2. Medicare Enrollees and Persons Served, Medicaid Recipients, and Program Expenditures

Table 1.1 relates data on the Medicare and Medicaid populations to program expenditures. In 1979, 16.9 million (60 percent) of the almost 28 million aged and disabled people enrolled in the Medicare program were provided reimbursable health services, and 21.5 million individuals received health services which were paid for by Medicaid.[5] On a State-by-State basis, almost 27 percent of all persons served under the Medicare program resided in New York, California, or Florida. In the Medicaid program, the top three States in terms of number of recipients in 1979 were New York, California, and Pennsylvania.

In 1979, $28 billion were spent on behalf of Medicare enrollees, while $20 billion were spent on behalf of Medicaid recipients. More Medicare reimbursements were made on behalf of California residents ($3.4 billion) than on behalf of residents of any other State. Reimbursements on behalf of residents of New York ($2.6 billion), Florida ($1.8 billion), and Pennsylvania ($1.8 billion) were next in size. Payments on behalf of Medicaid recipients were largest in the States of New York ($3.9 billion), California ($2.6 billion), Pennsylvania ($1.2 billion), and Michigan ($1.0 billion).

The average reimbursement per person served in the Medicare program in the U.S. was $1,663 in 1979. The average payment per recipient in the Medicaid program was $950. Medicare enrollees in Alaska had the largest reimbursement per person served ($2,607). Next in line were District of Columbia ($2,372), and Illinois ($2,153). Payments per recipient in the Medicaid program were highest in New York ($1,635), Minnesota ($1,558), and Alaska ($1,554).

Figures 1.1, 1.2, and 1.3 illustrate important differences between Medicare and Medicaid. Figure 1.1 shows Medicare's orientation toward acute care services, consistent with its statute. Inpatient hospital care accounts for 67.8 percent of total Medicare reimbursements (HI and SMI combined). Only 1.3 percent of Medicare reimbursements go to nursing homes, with coverage limited to short-term, post-hospital care. In contrast, while inpatient hospital services absorb only 31.4 percent of total Medicaid payments, payments for long-term care in nursing homes, both ICFs and SNFs, make up 42.3 percent of total Medicaid payments.

Medicare and Medicaid also differ in terms of the relative size and distribution of reimbursements among their enrollee and eligibility groups. Figure 1.2 shows that Medicare serves predominantly the aged who comprise 90 percent of the enrollees and for whom 87 percent of all reimbursements are paid.

Figure 1.3 illustrates the distribution of recipients and payments under the Medicaid program by basis of eligibility. The aged and disabled make up less than 30 percent of all recipients, but are responsible for over 67 percent of all payments. In contrast, children and adults eligible through AFDC criteria make up almost two-thirds of all recipients, but account for less than 30 percent of total payments.

3. The Administration of Medicare and Medicaid

At their inception in 1965, Medicare and Medicaid were administered separately, by different agencies of the Department of Health, Education, and Welfare. In 1977, the Health Care Financing Administration (HCFA) was created to administer both programs. Administrative control of Medicare was transferred to HCFA from the Social Security Administration (SSA); the administration of Medicaid was transferred to HCFA from the Social and Rehabilitiation Service (SRS). (SRS was then eliminated.) At the same time, several health and quality control functions were moved from the Public Health Service (PHS) to HCFA. Figure 1.4 compares the organizational structure prior to the 1977 creation of HCFA with the initial administrative structure of HCFA.

Although the creation of HCFA brought Medicare and Medicaid within a single administration, separate Medicare and Medicaid bureaus inhibited complete integration of the two programs. In addition, HCFA staff remained spread among three locations: Washington (the SRS location), Rockville (the PHS location), and Baltimore (the SSA location). In an effort to further enhance the coordination and efficiency of Medicare and Medicaid administration, the two programs were merged on May 28, 1979. HCFA also began the process of relocating the majority of its staff to Baltimore at that time.

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[5] No reliable national estimates of the total number of persons enrolled in Medicaid at any one time or over a period of time were available before April 1980.

TABLE 1.1

Medicare Enrollees and Reimbursements, and Medicaid Recipients and Payments, 1979

	Medicare Enrollees [1] (thousands)	Medicare Persons Served [2] (thousands)	Medicaid Recipients [3] (thousands)	Medicare Reimbursements [1] (millions)	Medicaid Payments (millions)	Medicare Reimbursement Per Person Served [2]	Medicaid Payment per Recipient
All Areas	27,858.7	16,875.4	21,540.0	$28,057.0	$20,473.5	$1,663	$ 950
United States	27,287.8	16,777.9	21,540.0	27,945.8	20,473.5	1,666	950
Alabama	480.2	277.2	327.9	409.9	239.6	1,479	731
Alaska [4]	11.7	7.3	17.2	19.0	26.7	2,607	1,554
Arizona	312.1	192.9	NA	299.5	NA	1,553	NA
Arkansas	341.9	200.9	213.4	255.8	192.2	1,273	904
California	2,565.1	1,774.8	3,373.7	3,332.6	2,558.0	1,878	758
Colorado	261.1	164.6	150.6	262.1	162.9	1,592	1,082
Connecticut	384.6	250.1	219.8	409.7	296.3	1,638	1,348
Delaware	64.4	42.7	44.6	72.4	38.4	1,696	862
District of Columbia	78.5	54.5	131.3	129.3	139.4	2,372	1,061
Florida	1,662.5	1,117.0	435.8	1,798.9	341.6	1,610	784
Georgia	570.7	336.8	401.3	455.9	382.8	1,354	954
Hawaii	77.6	50.2	110.2	75.5	86.3	1,504	783
Idaho	100.5	60.3	41.2	80.5	44.9	1,334	1,089
Illinois	1,329.6	729.8	1,015.8	1,571.0	991.8	2,153	976
Indiana	630.5	352.4	226.4	561.4	314.6	1,593	1,390
Iowa	411.1	235.2	169.1	336.2	208.3	1,429	1,232
Kansas	321.9	203.4	150.0	320.2	164.4	1,574	1,096
Kentucky	455.2	230.6	406.8	322.9	248.8	1,400	612
Louisiana	434.6	229.0	388.4	357.1	342.3	1,559	881
Maine	155.7	96.1	156.8	146.7	114.1	1,526	727
Maryland [5]	410.3	252.2	293.7	491.0	258.8	1,947	881
Massachusetts	768.3	502.4	1,046.3	943.0	901.8	1,877	862
Michigan	1,011.8	667.3	897.7	1,263.2	1,036.4	1,893	1,155
Minnesota	505.6	307.6	304.5	471.9	474.4	1,534	1,558
Mississippi	320.4	180.8	276.3	255.1	148.6	1,411	538
Missouri	697.1	398.5	338.1	690.6	238.6	1,733	706
Montana	92.1	52.5	41.9	71.4	53.0	1,359	1,265
Nebraska	216.8	115.3	69.4	192.4	94.3	1,669	1,360
Nevada	68.0	41.7	21.9	86.0	32.2	2,064	1,471
New Hampshire	109.7	67.9	44.0	93.5	60.1	1,377	1,366
New Jersey	923.7	602.5	662.7	965.3	659.5	1,602	995
New Mexico	124.8	74.2	85.7	105.8	58.4	1,427	682
New York	2,340.6	1,585.6	2,364.0	2,724.3	3,861.0	1,718	1,635
North Carolina	656.7	364.8	388.3	501.5	337.0	1,375	867
North Dakota	86.0	54.7	28.8	87.4	42.0	1,600	1,449
Ohio	1,278.6	742.8	725.8	1,274.9	670.0	1,716	923
Oklahoma	397.1	225.1	257.6	350.6	251.5	1,558	976
Oregon	322.5	192.6	225.5	298.2	162.1	1,549	719
Pennsylvania	1,647.4	1,023.9	1,390.3	1,735.8	1,188.0	1,695	854
Rhode Island	135.9	100.9	122.9	156.9	140.0	1,555	1,138
South Carolina	318.2	176.9	247.8	223.4	191.4	1,262	773
South Dakota	97.3	50.9	35.1	77.2	49.0	1,518	1,396
Tennessee	565.1	315.5	324.6	457.5	323.0	1,450	994
Texas	1,423.7	851.4	681.5	1,391.8	869.2	1,635	1,275
Utah	114.1	65.1	66.5	89.6	79.0	1,377	1,183
Vermont	63.8	40.4	49.1	57.0	52.3	1,412	1,066
Virginia [5]	542.4	314.3	313.4	489.6	312.0	1,558	995
Washington	456.2	292.9	273.6	386.2	291.0	1,318	1,062
West Virginia	271.6	141.6	104.4	196.4	93.0	1,387	890
Wisconsin	605.8	346.0	420.0	562.0	559.0	1,624	1,330
Wyoming	39.9	21.2	10.8	30.2	11.3	1,427	1,047
State Unknown	26.9	2.4	NA	9.2	NA	3,793	NA

(continued)

TABLE 1.1 (continued)

	Medicare Enrollees (thousands)	Medicare Persons Served (thousands)	Medicaid Recipients [3] (thousands)	Medicare Reimbursements (millions)	Medicaid Payments (millions)	Medicare Reimbursement Per Person Served	Medicaid Payment per Recipient
U.S. Territories & Possessions [6]	344.0	93.1	—	104.5	—	1,122	—
Guam	2.2	.5	—	1.1	—	2,185	—
Puerto Rico	336.3	90.7	1,490.3	101.4	97.5	1,118	65
Virgin Islands	4.7	1.7	19.1	1.9	2.4	1,123	126
Foreign Countries	227.0	4.4	NA	7.3	NA	1,515	NA

SOURCES: Medicare statistics are from Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA; Medicaid statistics are from Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA.

[1] As of July 1, 1979.
[2] Medicare data are for services incurred in calendar year 1979.
[3] Medicaid data are for services paid during fiscal year 1979.
[4] Arizona does not have a Medicaid program.
[5] Medicaid data from Massachusetts and Virginia received past the date that it was feasible to include them in this publication.
[6] Includes all other outlying areas.
"---" Data not available.
NA Not applicable.

The results of this reorganization, which became effective on June 20, 1979, are shown in Figure 1.5. The revised HCFA organization explicitly integrated the operation of Medicare and Medicaid by having each of the newly created bureaus and offices deal with specific programmatic aspects of both programs. This reduced duplication of efforts and enhanced consistency and coordination of Medicare and Medicaid (Perspectives, HCFA 79-20021).

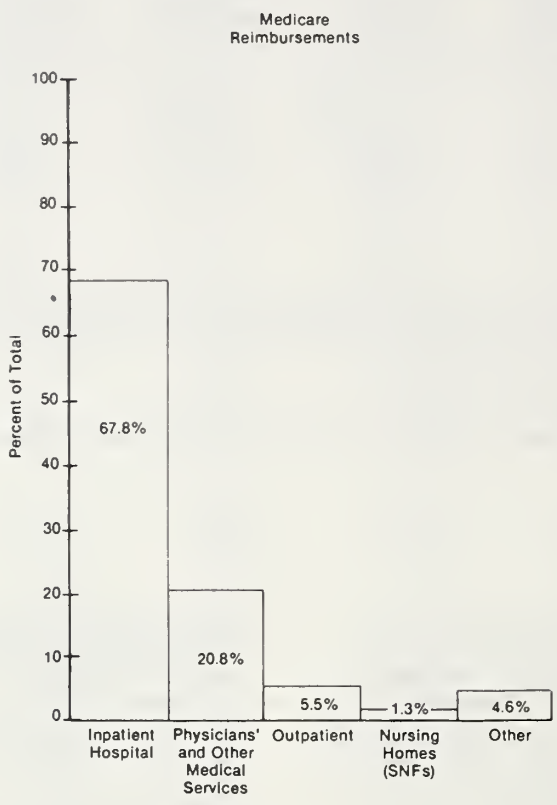
As part of a further move to streamline HCFA, it has been proposed that an intermediate level of Associate Administrators be established. Under this new alignment, five senior officials reporting to the Administrator and Deputy would cover all phases of HCFA's operations:

- Associate Administrator for Operations
- Associate Administrator for Policy
- Associate Administrator for Management and Support Services
- Associate Administrator for External Affairs
- Director, Office of Executive Operations

This new structure is outlined in Figure 1.6. HCFA will be working to implement this realignment. During this period, HCFA will continue to operate through its existing organization and management structure.

FIGURE 1.1

Distributions Of Medicare Reimbursements And Medicaid Payments
By Type Of Service, 1979



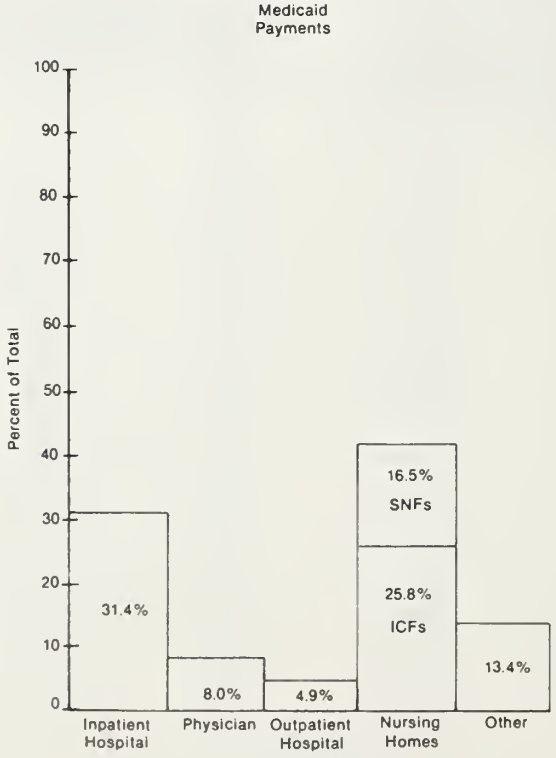


FIGURE 1.2

Distributions Of Medicare Enrollments And Reimbursements By Type Of Enrollee, 1979

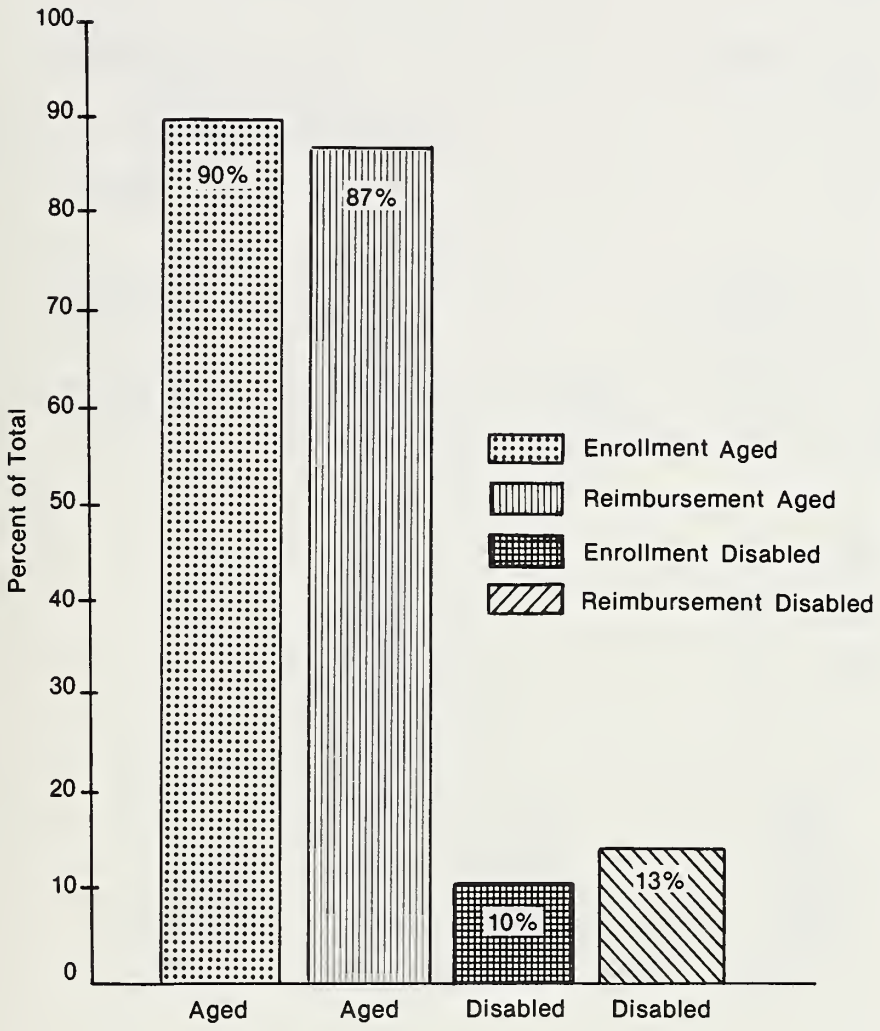


FIGURE 1.3

Distributions of Medicaid Recipients And Payments By Basis Of Eligibility, 1979

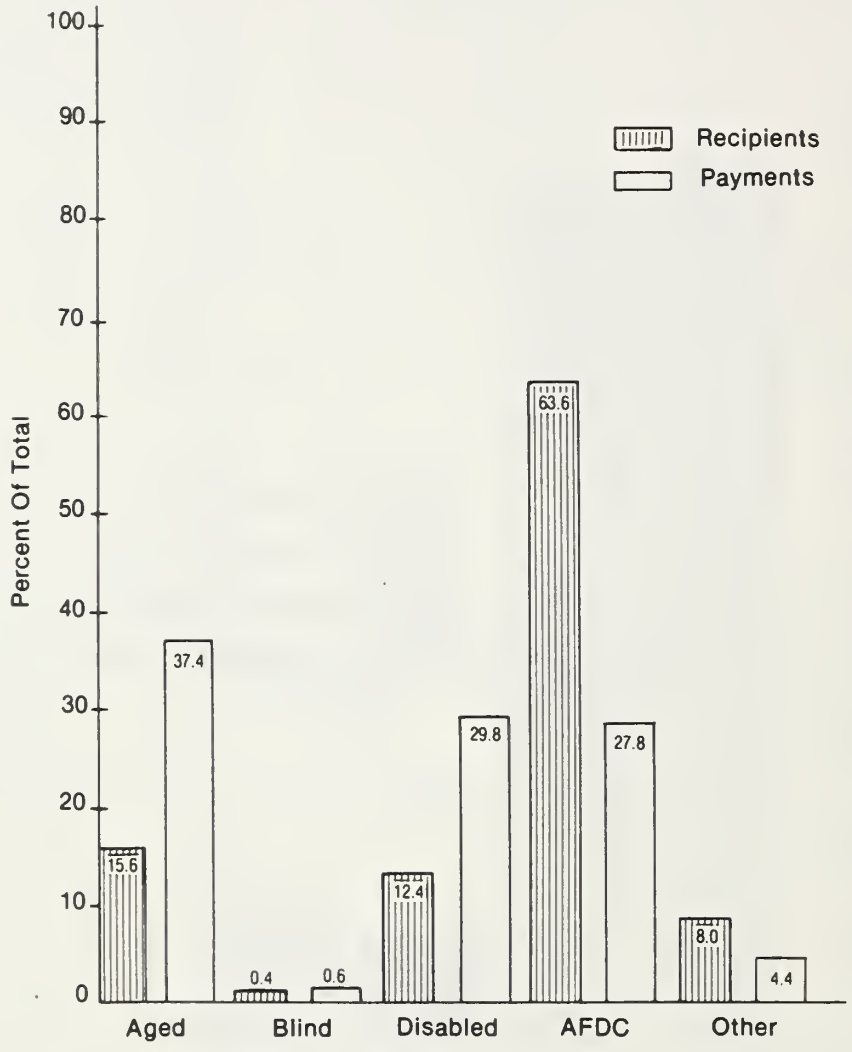


FIGURE 1.4
Organization For Health Care Financing

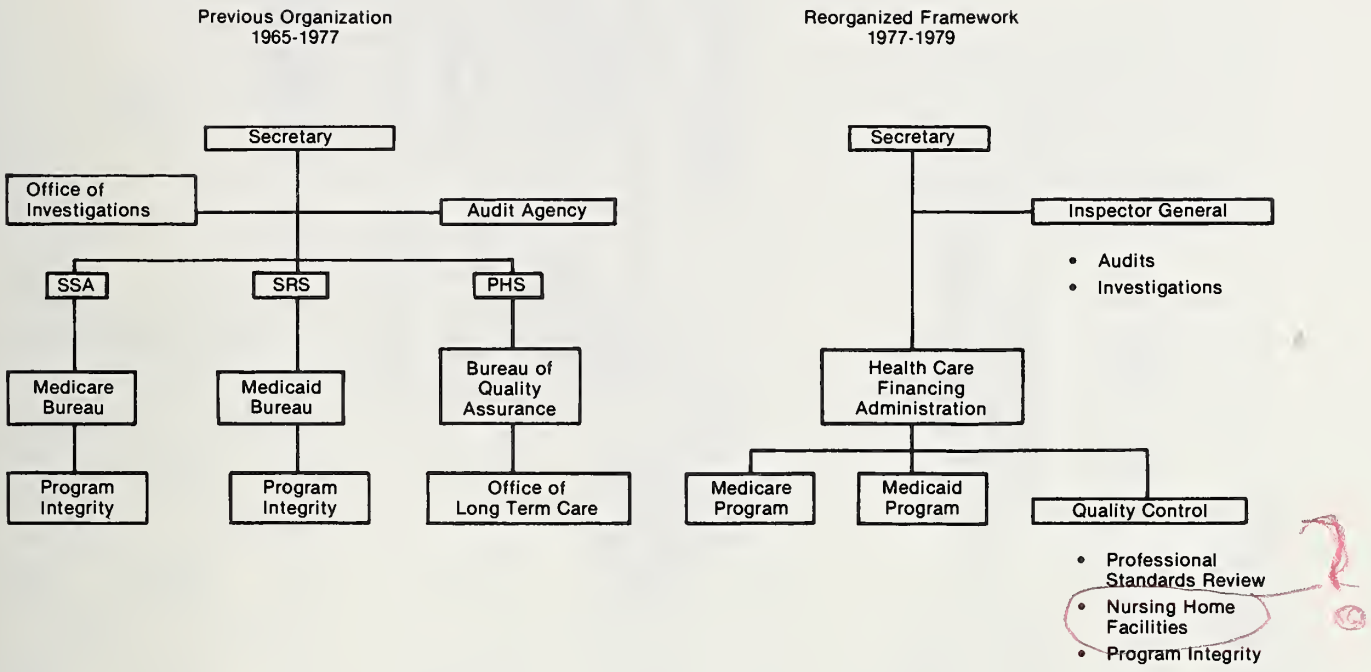


FIGURE 1.5
Health Care Financing Administration
Organization Chart, 1979-1981

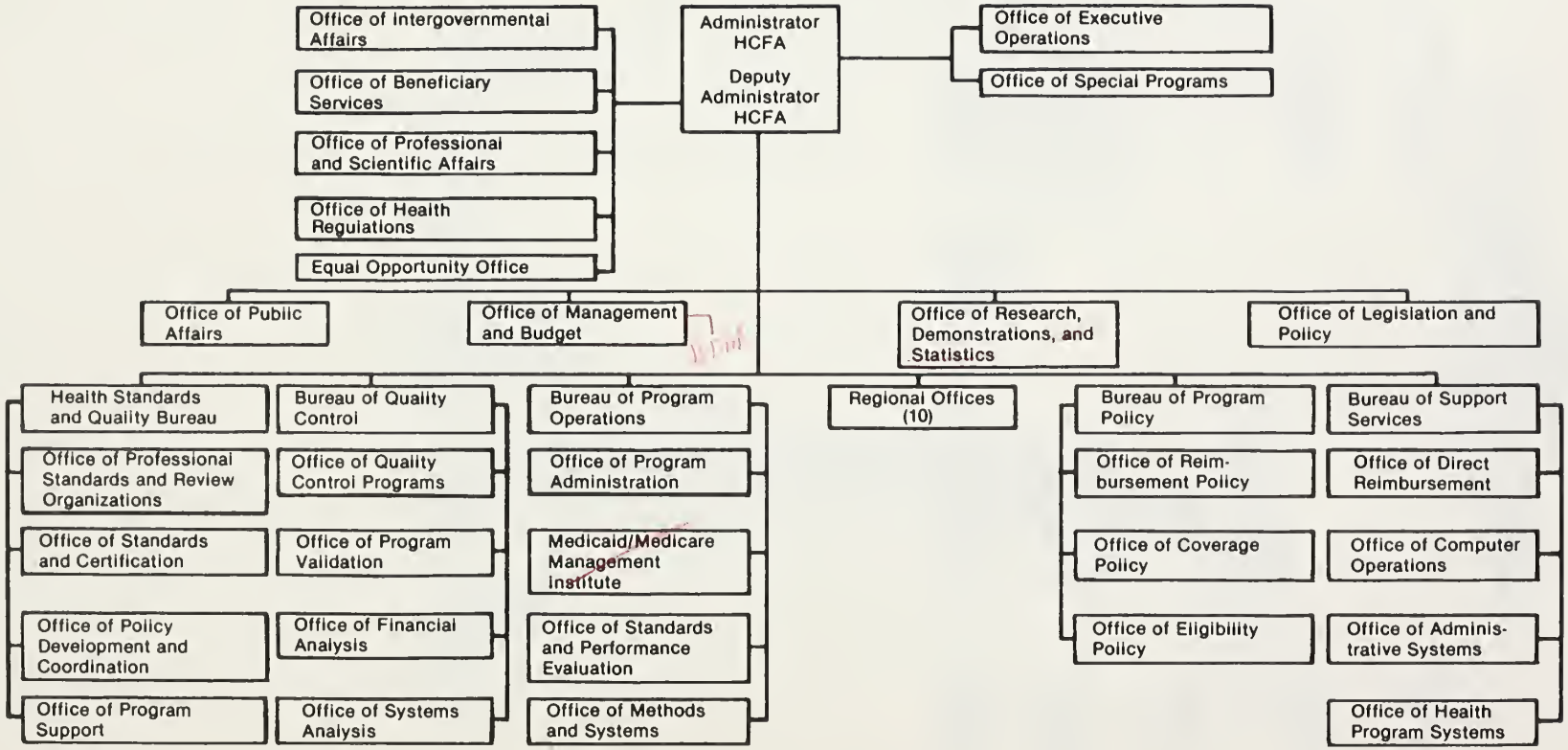
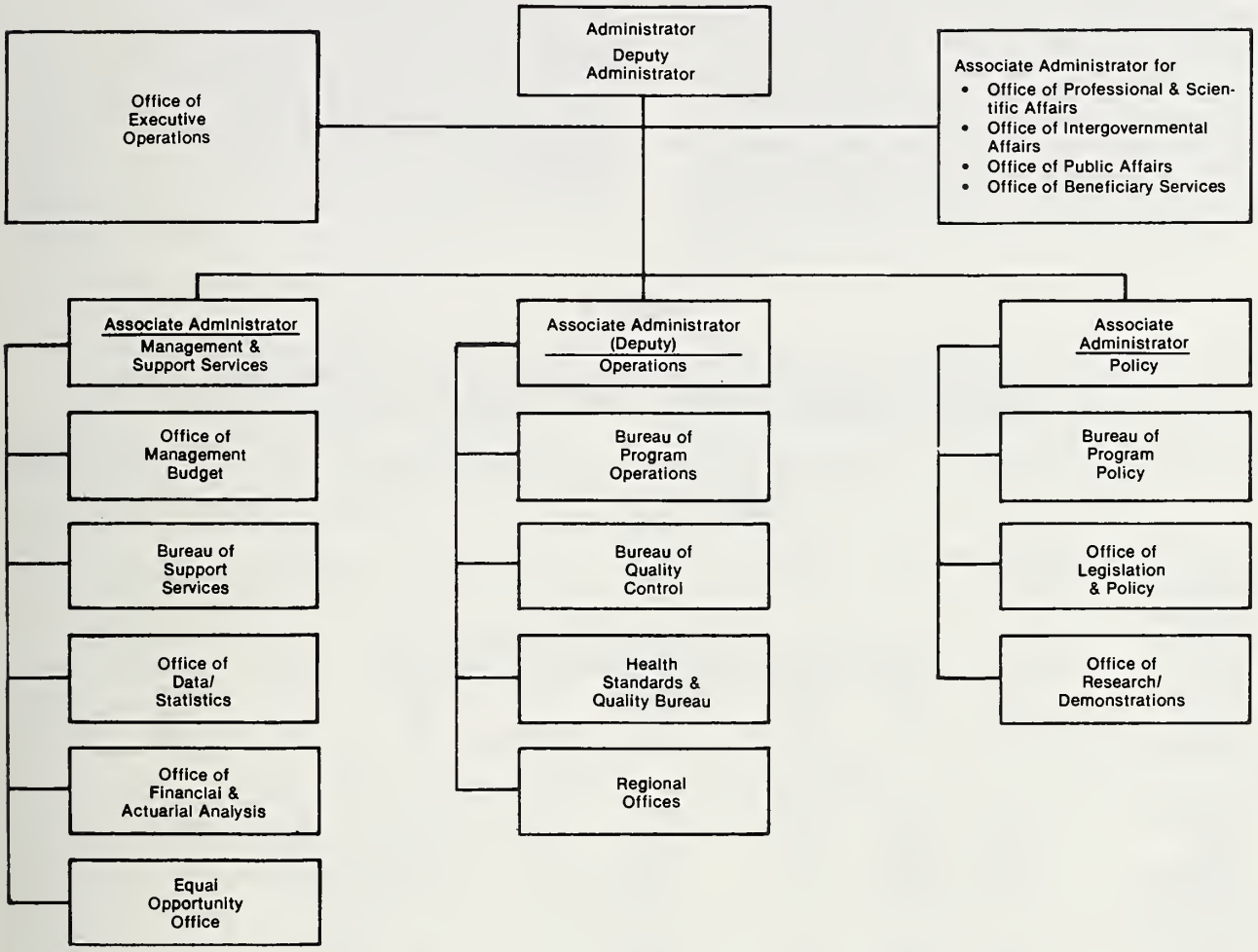


FIGURE 1.6
Proposed Organization Of HCFA Central Office



4. Medicare, Medicaid, and Total Expenditures for Personal Health Care

Table 1.2 shows the distribution of all national health care costs in 1977 by source of payment. The table shows the total amounts spent by various age groups for all personal health care, hospital care, physician care, and other medical care. Also displayed is the percentage distribution for each age and service group, by source of payment. Included is the percentage of these expenses paid for directly by individuals, paid by private insurance, and paid by public programs, including Medicare and Medicaid. The table clearly indicates that for the aged, public programs pay for a large portion of personal health care expenses (64 percent), including 88 percent of hospital expenditures. Medicaid paid a larger share of health care costs for the young (under 19 years) and the aged (65 and over) than for persons in other age groups. Medicaid is also the most important public program in terms of paying for care other than hospital and physicians' services. Overall, Medicare and Medicaid accounted for about 26 percent of personal health care expenditures in 1977 (Gornick, 1976; Hirsch, [in preparation]).

TABLE 1.2

Percentage Distribution of Health Care Expenditures by Source of Payment for Hospital Care, Physicians' Services, and all Other Health Care Services, Calendar Year 1977

Age Group and Service	Total Expenditures (millions)	Private				Public [1,2]			
		Total	Direct Payments	Private Health Insurance	Other	Total	Medicare	Medicaid	Other [3]
All Personal Health Care									
All Ages	$149,139	61.0%	31.8%	27.9%	1.3%	39.0%	14.6%	11.2%	13.2%
Under 19	18,259	71.5	38.1	32.7	0.7	28.5	0.1	15.6	12.8
19–64	87,578	71.2	31.9	37.4	1.9	28.8	3.0	8.9	16.9
65 & Over	43,303	36.1	29.1	6.6	0.4	63.9	44.2	13.8	5.9
Hospital Care									
All Ages	67,914	45.6	8.3	36.2	1.1	54.4	23.9	9.5	21.0
Under 19	6,551	54.6	3.7	50.7	0.2	45.4	—	25.0	20.4
19–64	42,466	59.2	10.7	46.9	1.6	40.8	4.9	9.6	26.3
65 & over	18,897	12.0	4.6	7.1	0.3	88.0	74.7	3.9	9.4
Physician Care									
All Ages	31,242	74.1	33.9	40.1	0.1	25.9	14.7	6.0	5.2
Under 19	4,771	84.4	38.7	45.7	—	15.6	0.4	12.1	3.1
19–64	18,848	84.5	35.7	48.6	0.1	15.5	2.4	5.6	7.5
65 & Over	7,623	41.8	26.2	15.5	—	58.2	54.2	3.1	0.9
All Other Care									
All Ages	49,984	73.9	62.5	9.0	2.4	26.1	1.9	16.7	7.5
Under 19	6,937	78.5	70.2	6.9	1.5	21.5	—	9.2	12.3
19–64	26,265	81.2	63.4	14.0	3.8	18.8	0.2	10.2	8.4
65 & Over	16,783	60.6	58.0	1.9	0.7	39.4	5.3	29.9	4.2

SOURCE: Charles R. Fisher, "Differences by Age Groups in Health Care Spending," *Health Care Financing Review* (Spring 1980), pp. 65-90.

[1] Some of the figures in this table differ from those presented in other tables. Differences occur for several reasons. For example, these figures are estimates; they also combine all inpatient and outpatient hospital care under the label hospital care, and all physician and other professional medical care under the label physician care.

[2] The expenditures and distribution of expenditures for Medicaid will not be consistent with other figures reported for Medicaid in this book. The discrepancies are due to the following factors: (1) Expenditures are reported for calendar year 1977 on Table 1.2 while all other tables report fiscal year data; (2) Age breakouts on Table 1.2 are not consistent with the standard age breakouts found on other Medicaid tables; and (3) Service categories on Table 1.2 are aggregated.

[3] Includes expenditures for health care by the Veterans Administration, the Department of Defense, workers compensation programs, state and local governments (except for Medicaid expenditures), and Federal medical public assistance programs (other than Medicare and Medicaid).

II. Medicare and Medicaid Trends

This chapter reports trends in the Medicare and Medicaid programs over much of the last decade. Section A describes changes in the number of Medicare enrollees and Medicaid recipients, by program category and by population characteristics. Data on Medicare and Medicaid expenditures — in total and by eligibility category — are presented in Section B. Section C reports and compares trends in the use of and expenditures for hospital inpatient and physicians' services in Medicare and Medicaid. Sections D and E present trend data for other services financed by the Medicare and Medicaid programs, respectively.

A. Enrollments and Recipients

1. Trends in Medicare Enrollees and Medicaid Recipients

As shown in Table 2.1, the number of aged and disabled Medicare enrollees increased at a rate of 2.9 percent per year over the period 1966 through 1979. The number of SMI enrollees increased a bit more rapidly than the number of HI enrollees. Enrollment jumped by more than 10 percent between 1972 and 1973, reflecting the extension of Medicare coverage to the disabled through the 1972 amendments to the Social Security Act. Prior to the 1972 amendments, only persons 65 and older were covered by Medicare.

From 1973 to 1977, the number of Medicaid recipients, that is, persons who actually received services paid for by Medicaid, increased by 3.9 percent a year.[6] The number of Medicaid recipients peaked in 1977. It has decreased in each of the two succeeding years at an annual rate of 3.1 percent. The number of recipients in 1979 was 9.8 percent greater than in 1973. Figure 2.1 plots the data reported in Table 2.1.

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[6] The Medicaid data presented in this report begins in FY 1973. That was the first full year of implementation of the reporting system upon which almost all Medicaid data presented in this report are based. Data prior to FY 1973 were reported in categories that are inconsistent with the post FY 1973 categories. Hence, pre-FY 1973 data are not presented in order to avoid erroneous inferences.

TABLE 2.1

Number of Medicare Enrollees by Type of Coverage, and Number of Medicaid Recipients, 1966-1979 (thousands)

Year	Medicare Enrollees by Type of Coverage[1]			Medicaid Recipients
	Hospital Insurance and/or Supplementary Medical Insurance Enrollees	Hospital Insurance	Supplementary Medical Insurance	
1966	19,108.8	19,082.5	17,736.0	—
1967	19,521.0	19,493.9	17,893.0	—
1968	19,821.0	19,769.7	18,804.8	—
1969	20,102.7	20,014.2	19,194.7	—
1970	20,490.9	20,361.2	19,584.4	—
1971	20,914.9	20,742.3	19,974.7	—
1972	21,332.1	21,115.3	20,351.3	—
1973	23,545.4	23,301.1	22,490.5	19,622.2
1974	24,201.0	23,924.1	23,166.6	21,117.0
1975	24,958.6	24,640.5	23,904.6	22,222.7
1976	25,662.9	25,312.6	24,614.4	22,890.9
1977	26,457.9	26,093.9	25,363.5	22,920.5
1978	27,164.2	26,777.3	26,074.1	22,197.9
1979	27,858.7	27,459.2	26,757.3	21,540.0
ACRG (%)	2.9	2.8	3.2	1.6[2]

SOURCES: Kathryn D. Barrett, "Persons Enrolled for Medicare, 1979," *Health Care Financing Notes* (January 1981), HCFA Pub. No. 03079; Medicaid Program Data Branch, Office of Research, Demonstrations and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] As of July 1 of each year.

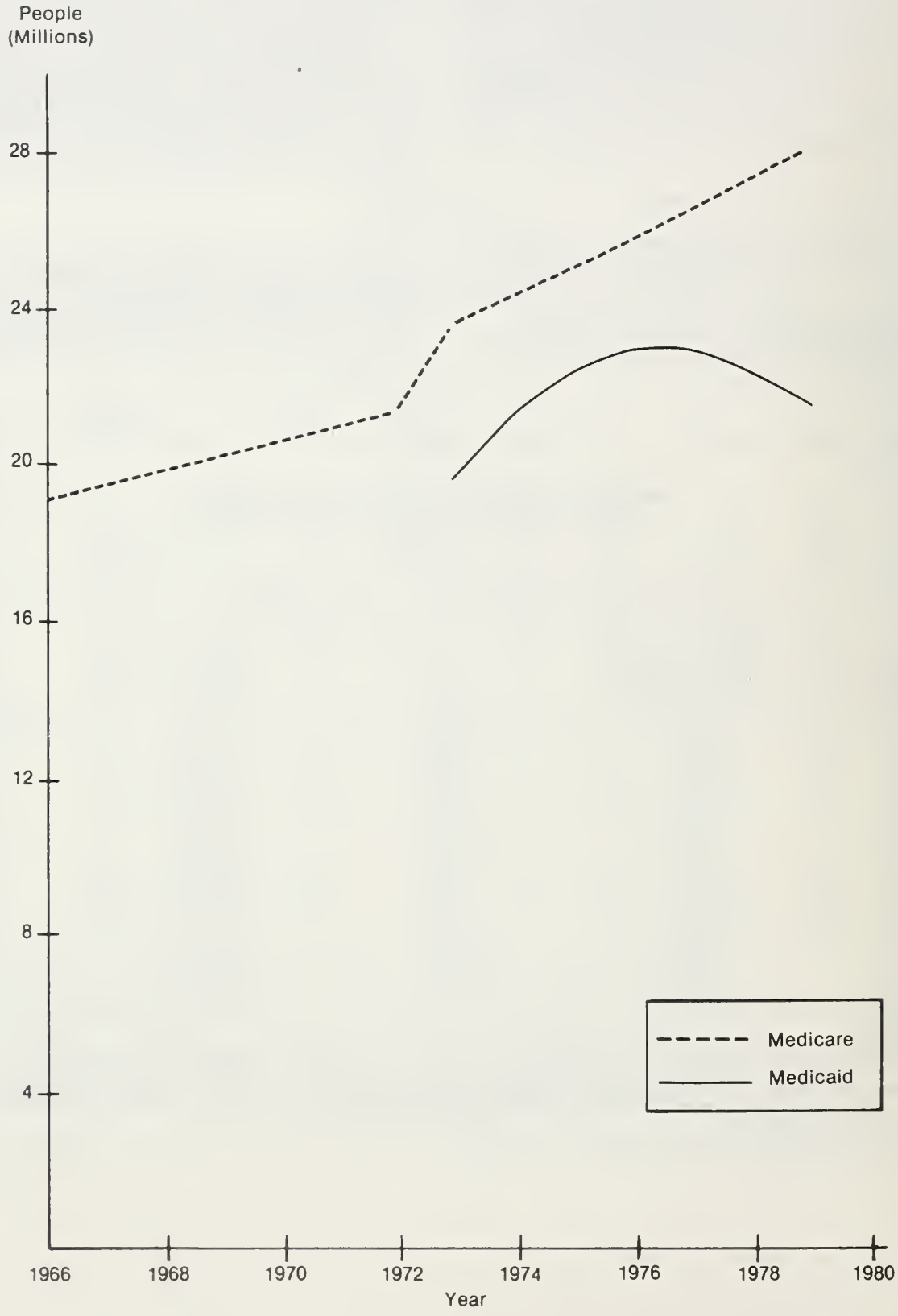
[2] The annual rate of growth was 3.9 percent between 1973 and 1976 and the number of recipients declined at an annual rate of 3.1 percent between 1977 and 1979.

ACRG Annual compound rate of growth.

"---" Data not available.

FIGURE 2.1

Numbers Of Medicare Enrollees And Medicaid Recipients
1966-1979



2. Number of Aged Medicare Enrollees Having HI and SMI Coverage, by Age, Sex, and Race, July 1, 1966-1978

Table 2.2 presents data by age, sex, and race on the number of aged persons who were enrolled for HI and SMI for the years 1966 through 1978. All of the groups specified in the table experienced increases in their enrollment, with SMI enrollments increasing more rapidly than HI enrollments in each demographic group. Under both programs, women, non-whites, and those aged 75 and older experienced greater enrollment increases than did other groups.

3. Number of Disabled Medicare Enrollees Having HI and SMI Coverage, by Age, Sex, and Race, July 1, 1973-1978

Table 2.3 presents data on trends in enrollment for all disabled persons and for ESRD-only enrollees by age, sex, and race. Data are provided for both HI and SMI. Annual rates of growth in the numbers of disabled enrollees have been much greater than those for aged enrollees (Table 2.2). Under HI, enrollments for the youngest and the oldest groups among all disabled increased the most. Rates of increase in enrollment were two to three times larger for people enrolled solely because of end-stage renal disease (ESRD) than for all disabled enrollees combined. Enrollments of both disabled and ESRD-only women increased more rapidly than did those of men. Whites and non-whites have had similar rates of increase in enrollment under HI. For the SMI program, increases by race were almost identical to those occurring in the HI program.

4. Trends in Medicaid Recipients by Maintenance Assistance Status and Basis of Eligibility

Table 2.4 shows data on trends in the number of Medicaid recipients by basis of eligibility and maintenance assistance status. Recipients are divided into those who receive welfare cash payments as well as Medicaid benefits, and those who receive medical assistance only. The total number of cash assistance recipients of Medicaid services increased at a rate of 1.6 percent per year between 1973 and 1979. The number of aged and blind cash assistance recipients decreased over that time at rates of -1.2 and -3.8 percent, respectively. The highest rate of growth was for recipients who were permanently and totally disabled. Most of this increase occurred between 1973 and 1977, when the total number of disabled recipients increased by more than half. The number of children under age 21, who comprise 48 percent of all cash-assistance Medicaid recipients, grew at an annual rate of 2.0 percent per year.

The number of Medicaid recipients who are not also recipients of cash assistance increased at a slightly lower rate than the number of cash assistance recipients, 1.5 percent per year. Among medical assistance only recipients, the number of disabled and AFDC-related adult recipients grew most rapidly, at rates of 8.6 and 6.8 percent per year, respectively.

5. Trends in Medicaid Recipients by Age, Sex, and Race

In Table 2.5, data on the age, sex, and race of Medicaid recipients are presented for 1973 through 1979. Data are limited to reporting States. As indicated, the race of significant numbers of recipients is not reported. Among recipients identified by age and sex, Table 2.5 indicates that the number of recipients age 65 and older decreased at an annual rate of 2.9 percent. All other age groups grew at positive rates ranging from 2.4 to 2.9 percent per year. The number of female recipients grew 3.5 times faster than the number of male recipients.

B. Expenditures

1. Trends in Medicare Reimbursements and Medicaid Payments

Table 2.6 presents data on Medicare reimbursements and Medicaid payments from 1966 through 1979. (These data are plotted in Figure 2.2.) For Medicare, total reimbursements grew at an annual rate of 16.8 percent. SMI reimbursements increased more rapidly than HI reimbursements. The large annual percentage increases in total reimbursements in 1974 and 1975 correspond to the entry of the disabled into the program. The entry of the disabled into the program also led to the acceleration of the rate of increase in SMI reimbursements. The costs of renal dialysis required by persons with end-stage renal disease are covered under SMI. A regular schedule of dialysis would cost over $20,000 per year per user.

Medicaid payments also showed a constantly increasing trend. Payments for the aged, blind, and disabled grew the fastest. As clearly indicated in Figure 2.2, annual percentage increases in Medicare reimbursements were higher than those for Medicaid payments.

2. Trends in Medicare Reimbursements, 1966-1979

Table 2.7 provides data on trends in Medicare reimbursements under Medicare program components by type of enrollee. A steady increase in reimbursements to each entitlement group resulted in a more than five-fold increase in total reimbursements. A portion of this increase is, of course, due to the extension of Medicare coverage to disabled persons in 1973. However, reimbursements for the disabled grew twice as fast as reimbursements for the aged. As a result, reimbursements for the disabled constituted 13.3 percent of total reimbursements in 1979, compared to 8.7 percent of the total in 1974.

3. Trends in Medicaid Payments

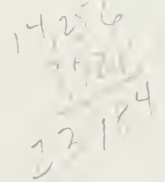
As shown in Table 2.8, Medicaid payments grew the fastest for services provided to the permanently and totally disabled among both cash assistance and medical assistance only recipients. The slowest rate of increase in payments occurred for children under the age of 21 who did not receive cash assistance. This contrasts sharply with the relatively rapid growth in payments for children also receiving cash assistance. As shown in Table 2.4, however, the number of children not receiving cash assistance declined by almost 35 percent over this period.

TABLE 2.2

Number of Aged Medicare Enrollees by Type of Coverage, Age, Sex, and Race, July 1, 1966-1978 (thousands)

	Hospital Insurance							Supplementary Medical Insurance						
		Age		Sex		Race [1]			Age		Sex		Race [1]	
Year	Total	65–74	75 +	Male	Female	White	Non-White	Total	65–74	75 +	Male	Female	White	Non-White
1966	19,082	11,990	7,092	8,133	10,950	17,042	1,445	17,736	11,186	6,550	7,534	10,202	15,938	1,264
1967	19,494	12,116	7,378	8,243	11,251	17,385	1,496	17,893	11,114	6,779	7,547	10,346	16,124	1,245
1968	17,770	12,158	7,611	8,318	11,452	17,632	1,525	18,805	11,561	7,244	7,878	10,927	16,877	1,368
1969	20,014	12,195	7,819	8,396	11,618	17,859	1,558	19,195	11,705	7,490	8,010	11,185	17,229	1,406
1970	20,361	12,316	8,045	8,507	11,855	18,187	1,608	19,584	11,873	7,711	8,132	11,452	17,576	1,472
1971	20,742	12,462	8,280	8,628	12,114	18,582	1,672	19,975	12,050	7,924	8,250	11,724	17,974	1,532
1972	21,115	12,641	8,474	8,744	12,371	18,930	1,693	20,351	12,248	8,104	8,360	11,991	18,325	1,557
1973	21,571	12,911	8,660	8,911	12,660	19,242	1,762	20,921	12,586	8,334	8,569	12,352	18,737	1,636
1974	21,996	13,182	8,814	9,005	12,991	19,601	1,809	21,422	12,925	8,496	8,694	12,727	19,149	1,704
1975	22,472	13,426	9,046	9,168	13,304	19,996	1,870	21,945	13,215	8,730	8,873	13,073	19,575	1,781
1976	22,920	13,691	9,229	9,324	13,596	20,382	1,916	22,446	13,529	8,917	9,047	13,399	19,995	1,845
1977	23,475	13,986	9,488	9,537	13,937	20,857	1,977	22,991	13,830	9,161	9,240	13,751	20,456	1,909
1978	23,984	14,259	9,725	9,728	14,256	21,289	2,036	23,531	14,119	9,412	9,436	14,094	20,904	1,978
ACRG (%)	1.9	1.5	2.7	1.5	2.2	1.4	2.9	2.4	2.0	3.1	1.9	2.7	2.3	3.8

SOURCE: Health Care Financing Administration, Kathryn Barrett, "Medicare: Persons Enrolled in the Health Insurance Program, 1977-1978," *HCFA Program Statistics Repo.*, in preparation.
ACRG Annual compound rate of growth.
[1] Does not include those enrollees whose race was unknown.



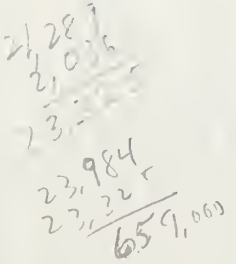


TABLE 2.3

Number of Disabled Medicare Enrollees by Type of Coverage, Age, Sex, and Race, July 1, 1973-1978 (thousands)

Year	Hospital Insurance									Supplementary Medical Insurance								
		Age				Sex		Race [1]			Age				Sex		Race [1]	
	Total	<35	35–44	45–54	55–64	Male	Female	White	Non-White	Total	<35	35–44	45–54	55–64	Male	Female	White	Non-White
	All Disabled																	
1973	1,730.5	192.4	218.0	438.8	881.4	1,118.8	611.8	1,444.9	**253.2**	1,569.9	174.9	194.7	390.2	810.0	1,003.3	566.6	1,307.7	**233.4**
1974	1,928.1	220.2	237.6	481.4	988.9	1,232.1	696.0	1,602.3	**287.1**	1,745.0	194.0	211.0	428.0	912.0	1,102.0	643.0	1,446.0	**263.1**
1975	2,168.4	254.3	261.7	530.0	1,122.4	1,380.9	787.5	1,800.9	**329.2**	1,959.2	225.8	232.3	469.2	1,032.0	1,230.6	728.7	1,622.3	**300.3**
1976	2,392.2	288.3	285.8	574.0	1,244.1	1,514.3	877.8	1,983.2	**370.9**	2,168.5	258.3	255.7	510.2	1,144.3	1,352.8	815.7	1,792.6	**339.6**
1977	2,619.4	322.6	310.6	617.3	1,368.9	1,654.2	965.2	2,163.0	**415.1**	2,372.6	290.0	278.8	548.7	1,255.2	1,475.4	897.3	1,954.3	**379.3**
1978	2,793.2	344.8	335.4	646.5	1,466.5	1,763.0	1,030.2	2,299.1	**447.8**	2,543.2	311.9	303.1	579.2	1,349.0	1,581.8	961.3	2,088.9	**411.0**
ACRG (%)	9.6	11.7	8.6	7.8	10.2	9.1	10.4	9.3	**12.1**	9.6	11.6	8.9	7.9	10.2	9.1	10.6	9.4	**12.0**
	Disabled—End-Stage Renal Disease Only																	
1973	6.4	2.2	1.4	1.7	1.1	3.4	3.0	4.6	**1.2**	6.3	2.1	1.3	1.7	1.1	3.3	2.9	4.5	**1.2**
1974	10.1	3.4	2.1	2.7	1.9	5.4	4.6	7.1	**2.3**	9.6	3.2	2.0	2.6	1.8	5.1	4.5	6.9	**2.1**
1975	12.7	4.3	2.4	3.3	2.6	6.7	6.0	8.6	**3.2**	12.1	4.1	2.3	3.2	2.6	6.4	5.7	8.2	**3.0**
1976	14.7	4.8	2.8	3.9	3.3	7.5	7.2	10.0	**3.8**	14.0	4.5	2.6	3.7	3.2	7.1	6.8	9.6	**3.5**
1977	16.5	5.1	3.0	4.4	3.9	8.4	8.2	11.3	**4.4**	15.5	4.8	2.8	4.2	3.7	7.8	7.7	10.7	**4.1**
1978	18.3	5.6	3.3	4.8	4.6	9.1	9.2	12.7	**4.8**	17.2	5.2	3.1	4.5	4.3	8.5	8.7	12.1	**4.4**
ACRG (%)	21.0	18.7	17.1	20.8	28.6	19.7	22.4	20.3	**32.0**	20.4	18.1	17.4	19.5	27.3	18.9	22.0	19.8	**29.7**

SOURCE: Health Care Financing Administration, Kathryn Barrett, "Medicare: Persons Enrolled in the Health Insurance Program, 1977-1978," *HCFA Program Statistics Report,* in preparation.
ACRG Annual compound rate of growth.
[1] Does not include those enrollees whose race was unknown.

TABLE 2.4

Number of Medicaid Recipients by Maintenance Assistance Status and Basis of Eligibility, 1973-1979 (thousands)

	Cash Assistance							Medical Assistance Only						
Year	Total [1]	Age 65+	Blind	Permanently and Totally Disabled	Children Under 21	Adults in AFDC	Other Title XIX [2]	Total [1]	Age 65+	Blind	Permanently and Totally Disabled	Children Under 21	Adults in AFDC	Other Title XIX
1973	14,519.9	2,226.9	83.6	1,425.4	7,017.3	3,616.7	150.0	5,102.3	1,268.6	17.7	378.7	1,641.4	449.7	1,346.2
1974	15,969.1	2,510.3	99.9	1,810.8	7,693.9	3,727.8	126.3	5,147.3	1,191.4	29.2	386.8	1,652.2	562.9	1,324.9
1975	16,805.0	2,443.6	84.9	1,830.3	8,393.3	4,052.9	NA	5,417.7	1,215.8	23.7	449.9	1,286.8	577.1	1,864.4
1976	17,201.0	2,408.3	76.7	1,984.8	8,512.0	4,219.3	NA	5,689.9	1,236.2	17.5	512.2	1,427.1	591.0	1,905.9
1977	17,103.4	2,408.7	76.1	2,178.1	8,361.8	4,078.5	NA	5,817.1	1,149.7	9.8	519.4	1,366.6	737.6	2,034.1
1978	16,622.6	2,194.0	64.9	2,101.4	8,247.7	4,014.6	NA	5,575.3	1,184.5	9.8	535.7	1,252.3	688.0	1,905.0
1979	15,964.8	2,070.9	66.7	2,028.0	7,923.8	3,875.3	NA	5,575.3	1,283.2	13.5	633.2	1,219.1	678.1	1,748.2
ACRG (%)	1.6	-1.2	-3.8	5.9	2.0	1.2	NA	1.5	0.2	-4.5	8.6	-5.0	6.8	4.4

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] Totals for each year include estimated recipient counts for nonreporting states.

[2] Cash assistance to other Title XIX recipients was phased out after 1974.

ACRG Annual compound rate of growth.

NA Not applicable.

TABLE 2.5

Number Of Medicaid Recipients By Age, Sex, and Race, 1973-1979[1] (thousands)

Year	Total	Age				Sex		Race		
		<6	6–20	21–64	65+	Male	Female	White	Non–White	Unknown
1973	19,622.2	2,890.4	5,943.6	6,292.8	4,495.4	7,222.9	12,399.3	—	—	—
1974	21,116.4	3,410.3	6,717.1	7,304.2	3,684.8	7,342.2	13,774.2	—	—	—
1975	22,222.7	3,366.7	7,329.0	7,735.7	3,791.2	7,762.4	14,460.3	8,315.5	6,165.9	7,741.3
1976	22,890.9	3,596.2	7,732.5	7,869.9	3,692.3	8,000.4	14,890.5	8,383.3	6,620.3	7,887.3
1977	22,920.5	3,504.5	7,359.8	8,267.4	3,788.8	8,065.7	14,854.8	8,471.9	6,421.3	8,027.3
1978	22,197.9	3,438.5	7,241.0	7,957.9	3,560.5	7,720.4	14,477.5	8,207.7	6,313.3	7,676.9
1979	21,540.0	3,401.2	6,856.2	7,511.0	3,771.7	7,474.4	14,065.6	8,043.5	7,125.9	6,370.6
ACRG (%)	1.6	2.7	2.4	2.9	–2.9	0.6	2.1	–0.8	3.6	–4.9

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.* National Annual Medicaid Statistics.

[1] A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to use an estimation technique with confidence. Consequently, ACRG for race categories should be used with caution since growth could occur simply because race had been reported more frequently, rather than because of an actual change in racial composition.

ACRG Annual compound rate of growth.

"—" Data not available.

TABLE 2.6

Medicare Reimbursements By Type of Coverage, And Medicaid Payments By Basis of Eligibility, 1966-1979 (millions)

	Medicare Reimbursements [1]				Medicaid Payments				
		Coverage				Basis of Eligibility			
Year	Total	Hospital Insurance	Supplementary Medical Insurance	% Change in Total Over Previous Year	Total	AFDC	SSI/ABD [2]	Other	% Change in Total Over Previous Year
1966	$1,019	$ 891	$ 128	NA	—	—	—	—	—
1967	4,549	3,353	1,197	446.5%	—	—	—	—	—
1968	5,697	4,179	1,518	25.2%	—	—	—	—	—
1969	6,603	4,739	1,865	15.9%	—	—	—	—	—
1970	7,099	5,124	1,975	7.5%	—	—	—	—	—
1971	7,868	5,751	2,117	10.8%	—	—	—	—	—
1972	8,643	6,318	2,325	9.9%	—	—	—	—	—
1973	9,583	7,057	2,526	10.9%	$8,640	$2,872	$5,315	$452	NA
1974	12,418	9,099	3,318	30.2%	9,983	5,093	6,159	425	15.5%
1975	15,588	11,315	4,273	24.9%	12,292	4,063	7,606	623	23.1%
1976	18,420	13,340	5,080	18.2%	14,135	4,598	8,827	710	15.0%
1977	21,774	15,737	6,038	18.2%	16,277	4,978	10,378	909	15.2%
1978	24,934	17,682	7,252	14.5%	17,966	5,343	11,646	974	10.4%
1979	29,331	20,623	8,708	17.6%	20,474	5,700	13,879	900	14.0%
ACRG (%)	16.8[3]	16.3[3]	18.0[3]	NA	15.5	12.1	17.3	12.2	NA

SOURCES The Board of Trustees, Federal Hospital Insurance Trust Fund, *1980 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* June 17, 1980, p. 27; Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1980 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund,* June 17, 1980, p. 20; and Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] Calendar years

[2] Supplemental Security Income/Aged, Blind and Disabled.

[3] ACRG computed for 1967 through 1979 because the 1966 figures do not cover a full year.

ACRG Annual compound rate of growth.

"—" Data not available.

NA Not applicable.

FIGURE 2.2

Total Medicare Reimbursements And Medicaid Payments
1966-1979

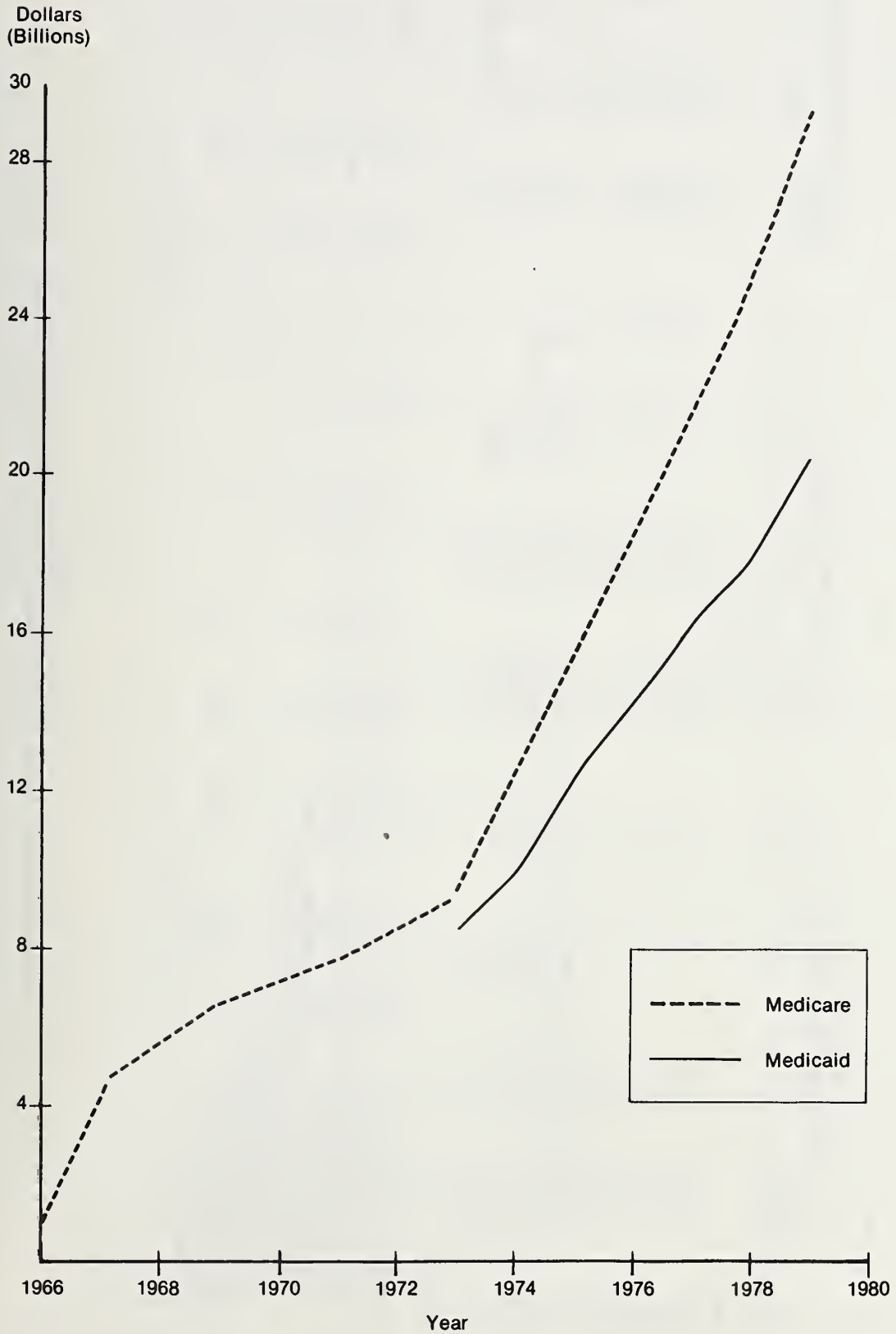


TABLE 2.7

Medicare Reimbursements, 1966-1979[1] (millions)

Year	Hospital Insurance and Supplementary Medical Insurance: Total Reimbursements	Aged[2]	Disabled[3]	ESRD[4]	Hospital Insurance: All HI Enrollees	Aged[2]	Disabled[3]	ESRD[4]	Supplementary Medical Insurance: All SMI Enrollees	Aged[2]	Disabled[3]	ESRD[4]
7/66–12/67	$ 5,145.2	$ 5,145.2	NA	NA	$ 3,839.9	$ 3,839.9	NA	NA	$ 1,305.3	$ 1,305.3	NA	NA
1968	5,289.5	5,289.5	NA	NA	3,766.9	3,766.9	NA	NA	1,522.6	1,522.6	NA	NA
1969	6,267.6	6,267.6	NA	NA	4,597.4	4,597.4	NA	NA	1,670.3	1,670.3	NA	NA
1970	6,572.0	6,572.0	NA	NA	4,740.3	4,740.3	NA	NA	1,831.6	1,831.6	NA	NA
1971	7,354.4	7,354.4	NA	NA	5,358.2	5,358.2	NA	NA	1,996.2	1,996.2	NA	NA
1972	8,019.4	8,019.4	NA	NA	5,835.7	5,835.7	NA	NA	2,183.7	2,183.7	NA	NA
1973	—	9,038.7	—	—	—	6,674.3	—	—	—	2,364.3	—	—
1974	11,238.0	10,257.5	$ 980.5	$ 184.4	8,118.4	7,454.4	$ 664.0	$ 44.6	3,119.6	2,803.1	$ 316.5	$139.8
1975	14,548.5	13,056.1	1,492.4	346.8	10,519.I	9,537.4	981.8	93.7	4,029.4	3,518.7	510.6	253.1
1976	17,619.0	15,636.5	1,982.5	492.0	12,793.9	11,495.8	1,298.1	134.3	4,825.1	4,140.7	684.4	357.7
1977	20,476.8	18,014.7	2,462.1	614.0	14,709.9	13,116.3	1,593.6	167.4	5,766.9	4,898.4	868.5	446.6
1978	23,542.7	20,579.1	2,963.6	—	16,630.3	14,740.7	1,889.7	—	6,912.4	5,838.4	1,073.9	—
1979	27,699.1	24,005.0	3,694.1	—	19,257.9	16,940.4	2,317.4	—	8,441.2	7,064.5	1,376.7	—
ACRG (%)	16.3[5]	14.8[5]	30.2	49.3[6]	16.0[5]	14.7[5]	29.2	55.4[6]	16.9[5]	15.0[5]	34.2	47.3[6]

SOURCE: Health Care Financing Administration, *Medicare: Reimbursements by State and County*, annual issues for 1966-1979.

[1] Preliminary data unadjusted for claims paid after data compilation. These data do not correspond to data on Table 2.6 primarily because Trust Fund data are based on interim reimbursements and retroactive adjustments made to institutional providers.

[2] For all enrollees aged 65 and over, including those with end-stage renal disease.

[3] For all enrollees under 65, including those with end-stage renal disease.

[4] For all aged and disabled enrollees with end-stage renal disease.

[5] ACRG computed for 1968 through 1979.

[6] ACRG computed for 1974 through 1977.

ESRD End-stage renal disease.

ACRG Annual compound rate of growth.

NA Not applicable.

"—" Data not available.

TABLE 2.8

Medicaid Payments by Maintenance Assistance Status and Basis of Eligibility, 1973-1979 (millions)

	Cash Assistance							Medical Assistance Only						
Year	Total[1]	Age 65+	Blind	Permanently and Totally Disabled	Children Under 21	Adults in AFDC	Other Title XIX[2]	Total[1]	Age 65+	Blind	Permanently and Totally Disabled	Children Under 21	Adults in AFDC	Other Title XIX
1973	$4,736.5	$985.0	$46.4	$1,335.6	$1,048.5	$1,277.8	$44.3	$3,903.3	$2,250.5	$18.5	$680.5	$377.6	$168.3	$407.9
1974	5,640.8	1,177.5	54.5	1,605.2	1,319.6	1,447.3	36.6	4,342.1	2,513.7	25.3	783.1	374.6	257.1	388.2
1975	6,624.7	1,371.9	56.5	1,831.6	1,634.4	1,730.3	NA	5,667.7	3,277.3	27.0	1,042.1	415.8	282.7	622.8
1976	7,657.6	1,456.9	55.2	2,282.4	1,903.2	1,960.0	NA	6,477.0	3,734.8	31.0	1,267.1	449.7	284.9	709.5
1977[3]	9,214.8	1,894.2	67.6	2,964.5	2,083.4	2,205.1	NA	7,062.2	3,935.5	31.5	1,492.3	368.2	324.9	909.8
1978[3]	10,004.9	2,020.2	68.7	3,279.1	2,310.9	2,326.0	NA	7,960.7	4,401.1	33.5	1,845.5	365.9	340.7	974.0
1979	10,726.0	2,076.6	75.6	3,671.2	2,434.4	2,468.3	NA	9,747.5	5,570.3	47.6	2,432.6	430.0	367.5	899.5
ACRG (%)	13.6	12.4	8.1	16.9	14.0	11.0	NA	15.3	15.1	15.8	21.2	2.2	13.0	13.2

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] Totals for each year include estimated payments for nonreporting states. Due to rounding, "Total" may not equal the sum of payments by basis of eligibility.

[2] Cash assistance to other Title XIX recipients was phased out and therefore not reported after 1975.

[3] Data for 1977 and 1978 have been adjusted to distribute small amounts of payments on behalf of persons whose basis of eligibility was unknown.

ACRG Annual compound rate of growth.

NA Not applicable.

4. Trends in Medicaid Payments by Age, Sex, and Race

Table 2.9 reports expenditures by the age, sex, and race of recipients. As in Table 2.5, race is not reported for many recipients. Among recipients for whom data are available, the table shows that there was little variation in the rates of growth of payments made on behalf of recipients in different age groups—all grew at rates between 14.0 and 15.5 percent per year. Payments on behalf of female recipients increased slightly faster than payments on behalf of male recipients.

C. Use of and Expenditures for Inpatient Hospital and Physicians' Services

Table 2.10 presents data on inpatient hospital use, including discharges, covered days of care, reimbursements for aged and disabled Medicare enrollees, and payments for Medicaid recipients. Annual compound rates of growth are presented for various years between 1967 and 1979 (Helbing, 1980). Consequently, rates of growth among groups are not directly comparable. Although in absolute terms disabled Medicare enrollees received the fewest services and the lowest reimbursements, they exhibited the highest rates of growth in discharges, days of care, and reimbursements. This is consistent with the rapid rate of increase in enrollment by disabled persons (Table 2.3).

In terms of days of care, disabled Medicare enrollees again exhibited the greatest growth rate which was 14.1 percent per year. Days of care for aged Medicare enrollees grew much more slowly at a rate of 2.4 percent per year. Finally, Medicaid payments for inpatient hospital services grew more slowly than Medicare reimbursements for either category of enrollees, but still at a rapid rate of 12.6 percent per year.

Table 2.11 reports data on Medicare reimbursements and Medicaid payments for physicians' services between 1966 and 1979. As with the use of inpatient hospital services, reimbursements for disabled Medicare enrollees grew the fastest at 28.2 percent per year. Medicaid payments for physicians' services grew at the slowest rate at 10.0 percent per year.

Figures 2.3 and 2.4 plot trends in Medicare reimbursements and Medicaid payments for inpatient hospital and physicians' services, respectively. Both figures show that Medicaid payments have been growing more slowly than Medicare reimbursements in recent years. To some extent, this reflects the declining number of Medicaid recipients since 1977 (Figure 2.1).

D. Trends for Selected Medicare Services

Figure 2.5 plots the trends in reimbursements for skilled nursing facilities, outpatient services, and home health services. The impact on outpatient services of the entry of the disabled into the program in 1973 is clearly shown. Tables 2.12, 2.13, and 2.14 present more detailed information on changes over time in these services.

1. Skilled Nursing Facilities

Table 2.12 shows that the use of and reimbursements for skilled nursing facilities decreased for aged enrollees between 1969 and 1977. Use and reimbursements declined each year between 1969 and 1972. They have grown since then, but not up to their 1969 levels. Disabled enrollees, however, have had positive rates of growth since 1974, the first full year of coverage for these persons. The number of discharges and days of care for the disabled increased at rates of 3.6 and 4.9 percent per year, respectively. As a result, total reimbursements for the disabled grew at a rate of 13.5 percent per year between 1974 and 1977, but they accounted for less than 4 percent of total Medicare reimbursements for SNF services in 1977.

2. Outpatient Services

Reimbursements for outpatient services grew rapidly for both aged and disabled enrollees (Table 2.13). Reimbursements on behalf of the disabled absorbed about one-third of total reimbursements for outpatient services. As noted earlier, this reflects the fact that renal dialysis represents a large component of all outpatient care provided Medicare enrollees.

3. Home Health Services

Table 2.14 presents data on the use of and reimbursements for home health services between 1969 and 1978. The rapid increases since 1972 in both visits and reimbursements coincide with the entry of the disabled into the program. Overall, reimbursements grew about 2.5 times faster than the number of visits.

E. Trends for Selected Medicaid Services

Figure 2.6 shows trends in Medicaid payments for skilled nursing and and intermediate care facilities. Trends in Medicaid payments for hospital outpatient services, home health services, and drug prescriptions are plotted in Figure 2.7. Detailed information on changes in these services is presented in Tables 2.15 through 2.20.

1. Skilled Nursing Facilities and Intermediate Care Facilities

Table 2.15 reports data on the use of and payments to skilled nursing facilities under Medicaid. Between 1973 and 1979 the number of discharges from skilled nursing facilities and total days of care declined at annual rates of -2.1 and -1.1 percent, respectively. Neither measure of use has exhibited a steady trend over this period. Both declined between 1973 and 1976, but have fluctuated since then. In spite of these fluctations in use, payments grew steadily at an annual rate of 9.0 percent.

Data on trends in the use of and payments to intermediate care facilities between 1975 and 1979 are presented in Table 2.16. Payments grew at an annual rate of 17.6 percent, even though the numbers of recipients and days of care grew more slowly at rates of 3.8 and 4.3 percent per year.

TABLE 2.9

Medicaid Payments by Age, Sex, and Race, 1973-1979[1] (millions)

Year	Total	Age				Sex		Race		
		<6	6–20	21–64	65+	Male	Female	White	Non–White	Unknown
1973	$8,640	$537.4	$1,067.9	$3,696.2	$3,338.5	$2,886.6	$5,753.4	—	—	—
1974	9,983	601.0	1,335.7	4,140.0	3,906.3	3,235.5	6,747.5	—	—	—
1975	12,292	720.3	1,719.7	5,042.2	4,809.9	3,924.8	8,367.2	$5,944.2	$2,646.3	$3,701.5
1976	14,135	883.4	2,052.4	5,856.1	5,343.0	4,550.1	9,584.9	6,666.3	3,131.7	4,337.0
1977	16,277	1,002.7	2,465.0	6,881.9	5,926.5	5,286.8	10,990.2	8,153.4	3,554.4	4,569.3
1978	17,966	1,148.0	2,522.4	7,533.1	6,762.4	5,910.8	12,055.2	9,039.9	4,032.4	4,893.7
1979	20,474	1,244.8	2,712.8	8,523.3	7,995.1	6,678.6	13,795.4	11,053.1	5,272.0	4,148.9
ACRG (%)	14.4	14.0	15.5	13.9	14.6	14.0	14.6	15.5	17.2	2.9

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to use an estimation technique with confidence. Consequently, ACRG for race categories should be used with caution since growth could occur simply because race had been reported more frequently, rather than because of an actual change in racial composition.

ACRG Annual compound rate of growth.

"—" Data not available.

TABLE 2.10

Use of Inpatient Hospitals Under Medicare and Medicaid, 1967-1979

Year	Discharges (thousands) Medicare Aged	Discharges (thousands) Medicare Disabled	Discharges (thousands) Medicaid	Days of Care[1] (thousands) Medicare Aged	Days of Care[1] (thousands) Medicare Disabled	Days of Care[1] (thousands) Medicaid	Medicare Reimbursements (millions) Aged	Medicare Reimbursements (millions) Disabled	Medicaid Payments (millions)
1967	5,228	NA	—	68,487	NA	—	$ 2,760	NA	—
1968	5,641	NA	—	75,589	NA	—	3,509	NA	—
1969	5,852	NA	—	77,246	NA	—	4,085	NA	—
1970	5,951	NA	—	75,578	NA	—	4,481	NA	—
1971	6,090	NA	—	74,298	NA	—	5,036	NA	—
1972	6,380	NA	—	75,284	NA	—	5,576	NA	—
1973	6,751	—	4,152	77,637	—	30,456	6,245	—	$2,660
1974	7,030	604	4,198	79,770	6,378	32,676	7,209	$ 621	2,887
1975	7,285	724	4,508	80,135	7,370	34,122	8,859	876	3,411
1976	7,607	863	4,549	82,916	8,661	31,623	10,589	1,183	3,938
1977	7,768[2]	971[2]	5,106	82,984[2]	9,600[2]	35,571	12,045[2]	1,475[2]	4,603
1978	8,266	1,083	5,871	88,971	10,815	35,313	14,229	1,826	4,985
1979	—	—	6,060	—	—	35,343	—	—	5,650
ACRG (%)	4.3	15.7	6.3	2.4	14.1	2.5	16.1	30.9	12.6

SOURCES: Charles Helbing, "Ten Years of Short-Stay Hospital Use and Costs Under Medicare: 1967-1976," *Health Care Financing Research Report* (August 1980), HCFA Pub. No. 03053, and unpublished data, Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA; Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics*.

[1] For Medicare, Days of Care includes only days covered by Medicare, i.e., a day of inpatient hospital care during which services covered by Medicare and determined to be medically necessary by the Professional Standards Review Organization or the Utilization Review Committee were furnished to a person eligible for Hospital Insurance (HI) benefits.

[2] Represents short-stay hospital utilization and cost estimates based on discharge stay records processed and recorded in CFA as of July 1978. These estimates are incomplete to the extent that approximately 2% of the discharge stay records for 1977 were not included in the file used to prepared the table.

ACRG Annual compound rate of growth.

"—" Data not available

NA Not applicable.

TABLE 2.11

Medicare Reimbursements for Physicians' and Other Medical Services and Medicaid Payments for Physicians' Services, 1966-1979 (millions)

Year	Medicare Reimbursements[1] Aged	Medicare Reimbursements[1] Disabled	Medicaid Payments
1966	$ 431.0	NA	—
1967	1,223.8	NA	—
1968	1,437.0	NA	—
1969	1,609.0	NA	—
1970	—	NA	—
1971	1,847.7	NA	—
1972	2,028.8	NA	—
1973	2,112.0	—	$ 925.9
1974	2,534.0	$206.2	1,083.4
1975	3,050.0	295.2	1,247.7
1976	3,633.0	389.1	1,388.6
1977	4,177.0	481.5	1,525.5
1978	5,145.0	556.5	1,595.9
1979	—	—	1,637.5
ACRG (%)	13.9[2]	28.2	10.0

SOURCES: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, *Medicare Health Insurance for the Aged and Disabled, 1976-1978: Summary—Utilization and Reimbursement by Person,* in preparation; Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] Includes reimbursements for physicians' services, ambulance services, independent laboratory services, durable medical equipment, and prosthetic devices. Therefore, these data are not directly comparable to Medicaid payments, which cover only physicians' services.

[2] ACRG computed for 1967 through 1978 because the 1966 figure does not cover a full year.

ACRG Annual compound rate of growth.

"—" Data not available.

NA Not applicable.

TABLE 2.12

Use of and Reimbursement for Skilled Nursing Facilities Under Medicare by Type of Enrollee, 1969-1977

Year	Discharges (thousands) Aged	Discharges (thousands) Disabled[1,2]	Days of Care (thousands) Aged	Days of Care (thousands) Disabled[2]	Reimbursements (millions) Aged	Reimbursements (millions) Disabled[2]
1969	367.9	NA	14,467.0	NA	$277.3	NA
1970	277.4	NA	9,901.0	NA	200.3	NA
1971	237.8	NA	7,230.0	NA	164.7	NA
1972	218.0	NA	5,837.0	NA	140.8	NA
1973	237.2	2.2	6,372.0	51.0	157.7	$1.5
1974	262.8	8.0	7,185.0	216.0	197.4	6.7
1975	252.1	8.2	6,618.0	222.0	195.6	7.6
1976	255.6	8.7	6,808.0	232.0	219.4	8.6
1977	260.8	8.9	7,145.0	249.0	243.8	9.8
ACRG (%)	–4.2	3.6[3]	–8.4	4.9[3]	–1.6	13.5[3]

SOURCE: Charles Helbing, "Medicare: Use of Skilled Nursing Facilities, 1976-1977, *"Health Care Financing Notes,* HCFA Pub. No. 03021.

[1] Includes SNF discharges with at least one day of covered care under Medicare. Excludes stays for enrollees who had exhausted their SNF benefits and for whom no discharge record was received.

[2] Preliminary estimates.

[3] ACRG computed for 1974 through 1977 because the 1974 figure does not cover a full year.

ACRG Annual compound rate of growth.

NA Not applicable.

FIGURE 2.3

Medicare Reimbursements And Medicaid Payments For Inpatient Hospital Services, 1967-1979

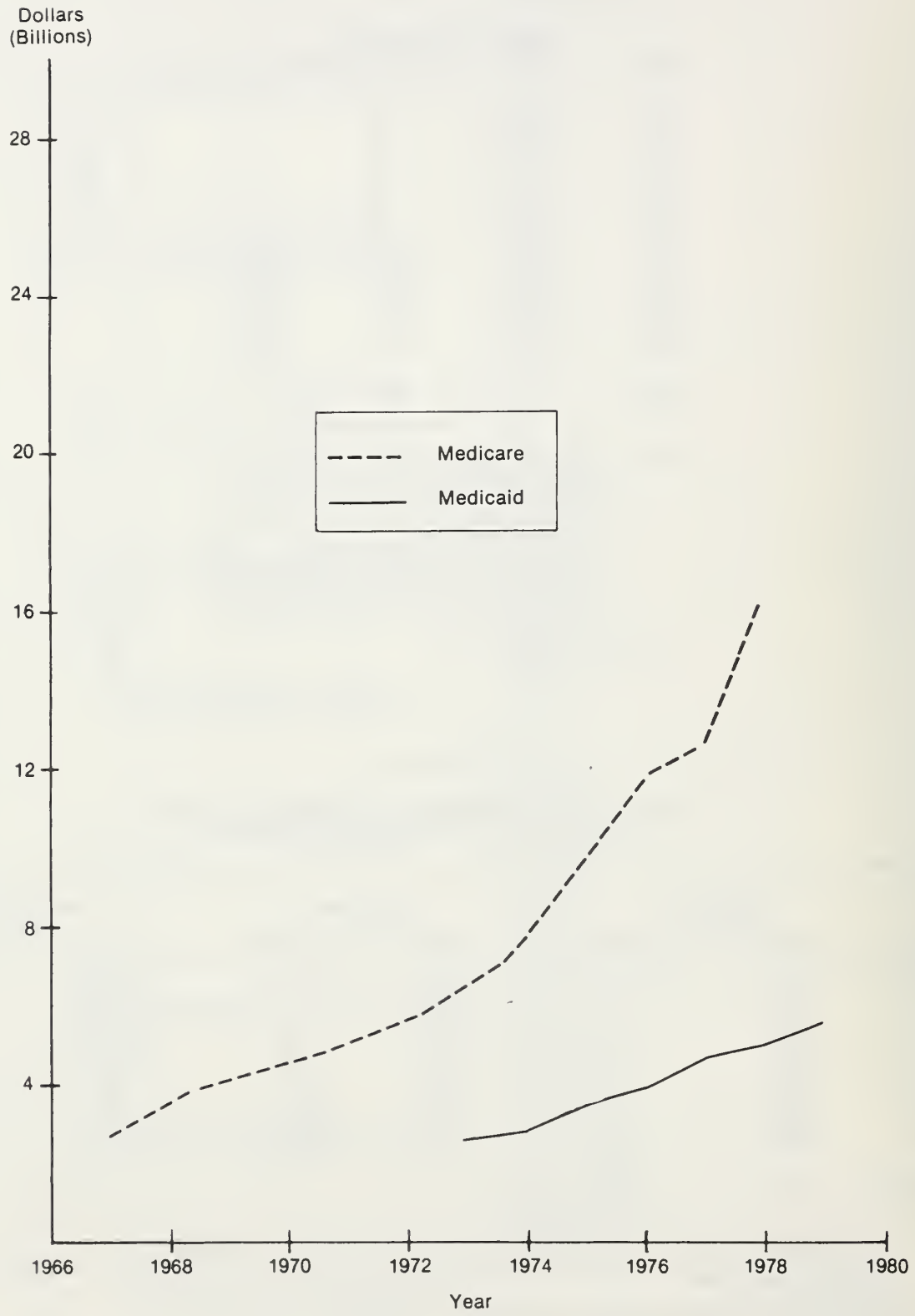
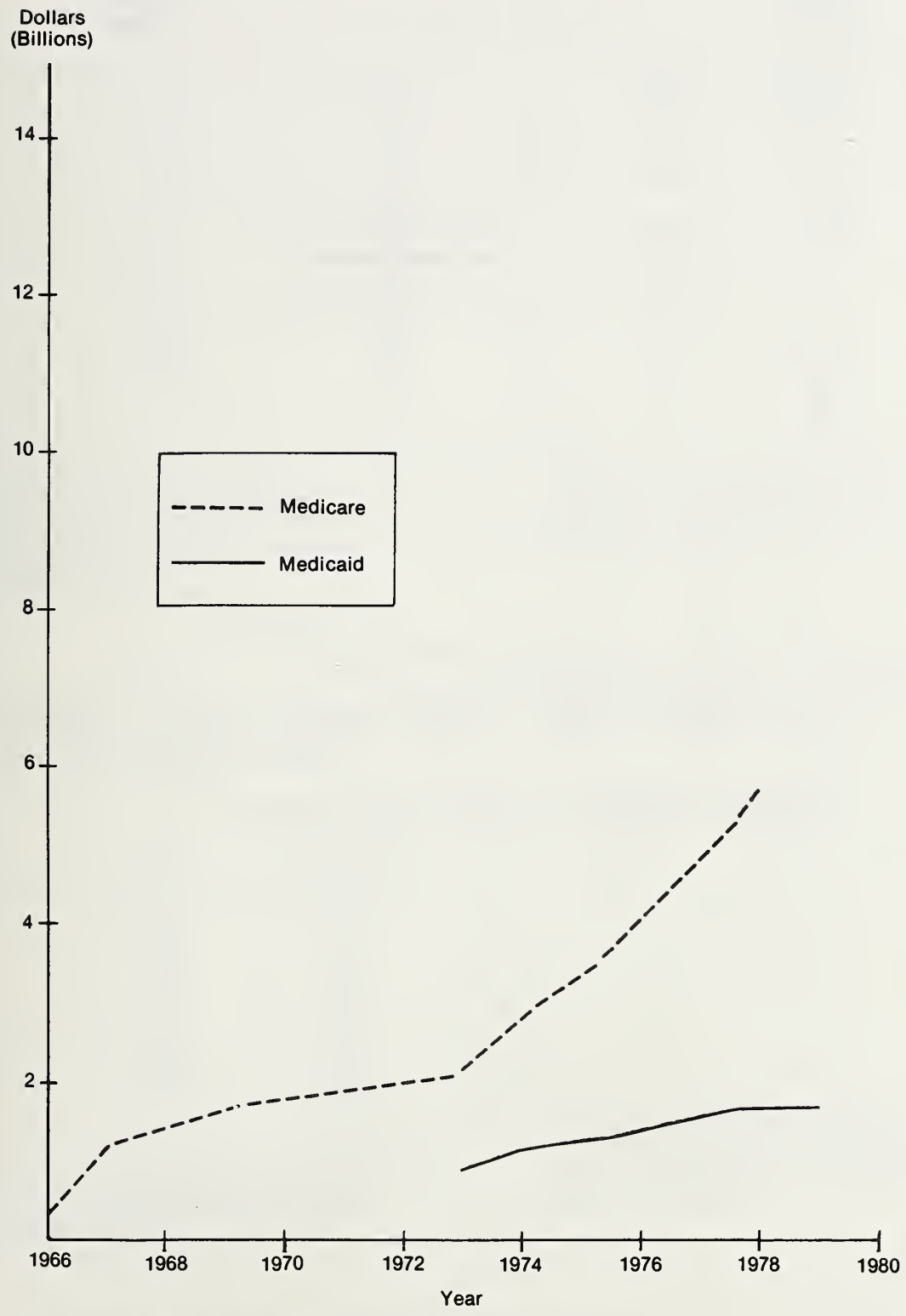


FIGURE 2.4

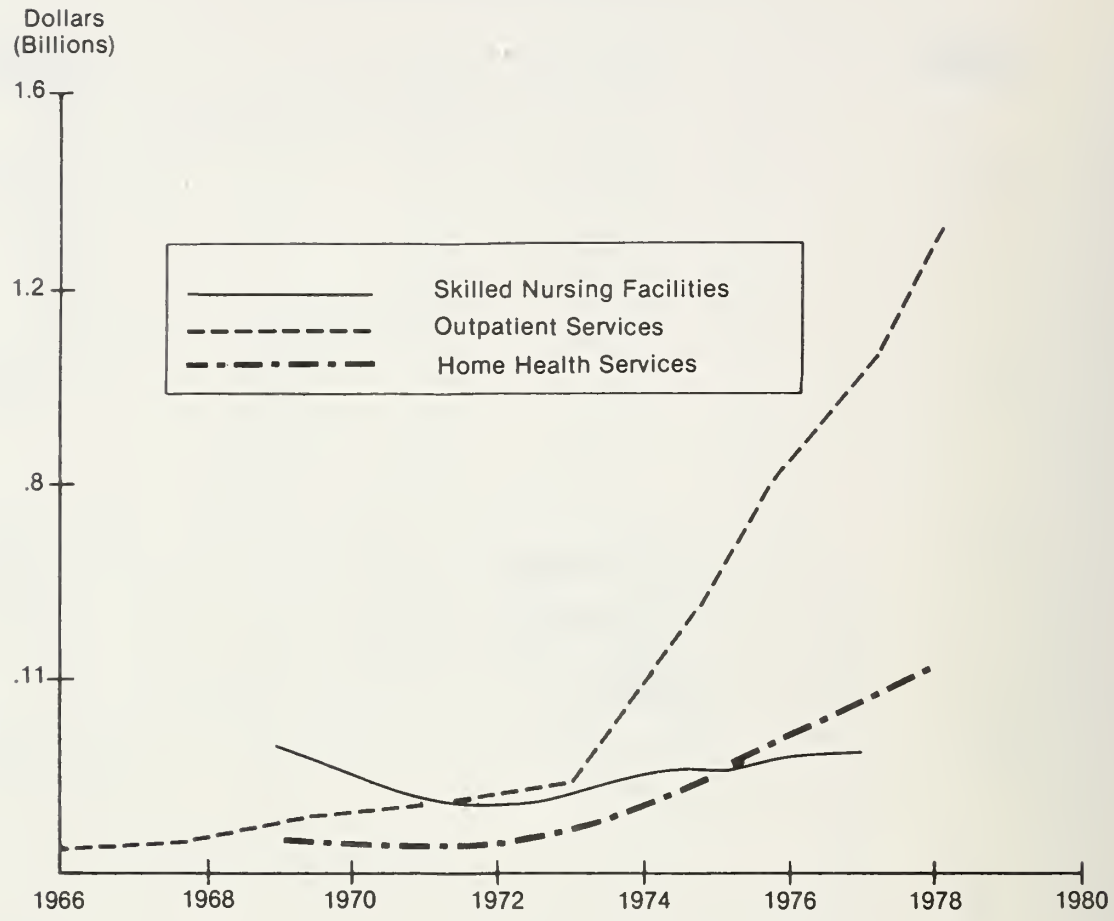
Medicare Reimbursements For Physicians' And Other Medical Services And Medicaid Payments For Physicians' Services, 1966-1979



*Vertical scale expanded by a factor of 2 over previous figures.

FIGURE 2.5

Medicare Reimbursements For Selected Services
1966-1978



*Vertical Scale expanded by a factor of 10 over Figure 2.2.

TABLE 2.13

Reimbursements for Outpatient Services Under Medicare by Type of Enrollee, 1966-1978 (millions)

Year	Aged	Disabled
1966	38.3	NA
1967	56.7	NA
1968	78.6	NA
1969	103.1	NA
1970	—	NA
1971	124.5	NA
1972	148.2	NA
1973	179.2	—
1974	252.5	145.3
1975	374.4	221.2
1976	516.2	308.8
1977	649.0	391.7
1978	798.0	480.4
ACRG (%)	27.2 [1]	34.8

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, *Medicare: Health Insurance for the Aged and Disabled, 1976-1978: Summary—Utilization and Reimbursement by Person*, in preparation.
[1] ACRG computed for 1967 through 1978 because the 1966 figure does not cover a full year.
ACRG Annual compound rate of growth.
"---" Data not available.

TABLE 2.14

Use of and Reimbursements for Home Health Services Under Medicare, 1969-1978

Year	Visits (thousands)	Reimbursements (millions)
1969	8,500	$ 78.1
1970	6,000	61.5
1971	4,800	56.8
1972	5,200	65.9
1973	6,400	92.9
1974	8,200	144.3
1975	10,900	217.0
1976	13,500	294.6
1977	15,600	366.5
1978	17,100	426.9
ACRG (%)	8.1	20.8

SOURCE: Wayne Callahan, "Medicare: Use of Home Health Services, 1978," *Health Care Financing Notes* (June 1980), HCFA Pub. No. 03025.
ACRG Annual compound rate of growth.

TABLE 2.15

Use of and Payments to Skilled Nursing Facilities Under Medicaid, 1973-1979

Year	Recipients (thousands)	Days of Care (thousands)	Payments (millions)
1973	677.9 [1]	123,082.7 [1]	$1,958.9 [1]
1974	646.0 [2]	121,006.0 [2]	2,001.9 [2]
1975	621.4	118,775.0	2,446.2
1976	586.2	108,774.5	2,488.4
1977	605.6	116,760.7	2,686.9
1978	615.3	115,738.9	3,093.6
1979	599.1	115,557.1	3,368.8
ACRG (%)	-2.1	-1.1	9.0

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics*.
[1] Michigan ICFs included with SNFs.
[2] West Virginia, Missouri, and North Carolina ICFs included with SNFs.
ACRG Annual compound rate of growth.

TABLE 2.16

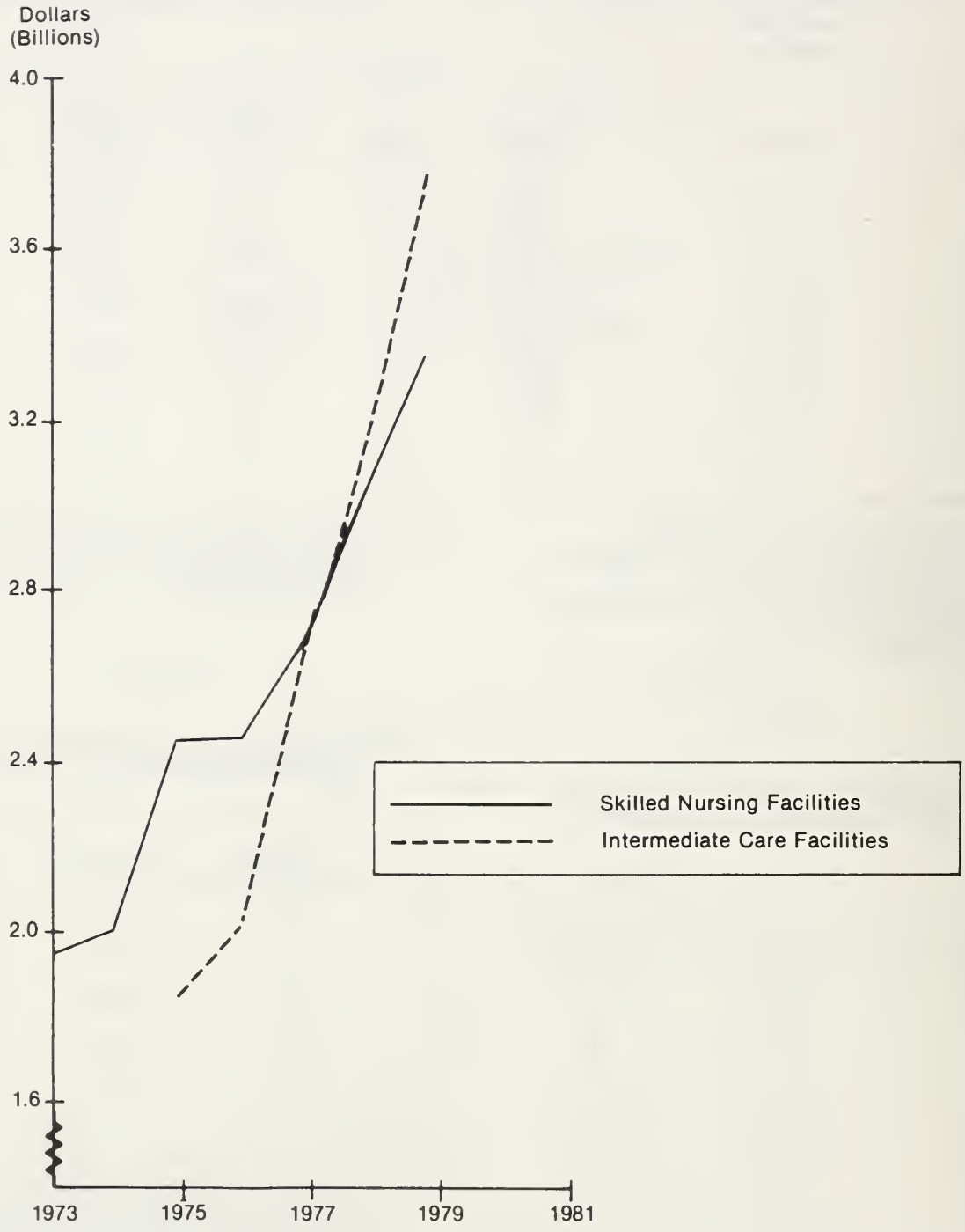
Use of and Payments to Intermediate Care Facilities Under Medicaid,[1] 1975-1979

Year	Recipients (thousands)	Days of Care (thousands)	Payments (millions)
1975	652.2	157,483.7	$1,866.7
1976	679.6	166,805.9	2,189.1
1977	735.7	172,088.1	2,647.4
1978	729.6	167,967.8	3,120.8
1979	760.0	187,375.9	3,770.9
ACRG (%)	3.8	4.3	17.6

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstration, and Statistics, HCFA, *National Annual Medicaid Statistics*.
[1] Data for all intermediate care facilities other than those for the mentally retarded. Data for 1973 and 1974 are not included in this table since ICF data were not reported as a separate category in those years.
ACRG Annual compound rate of growth.

FIGURE 2.6

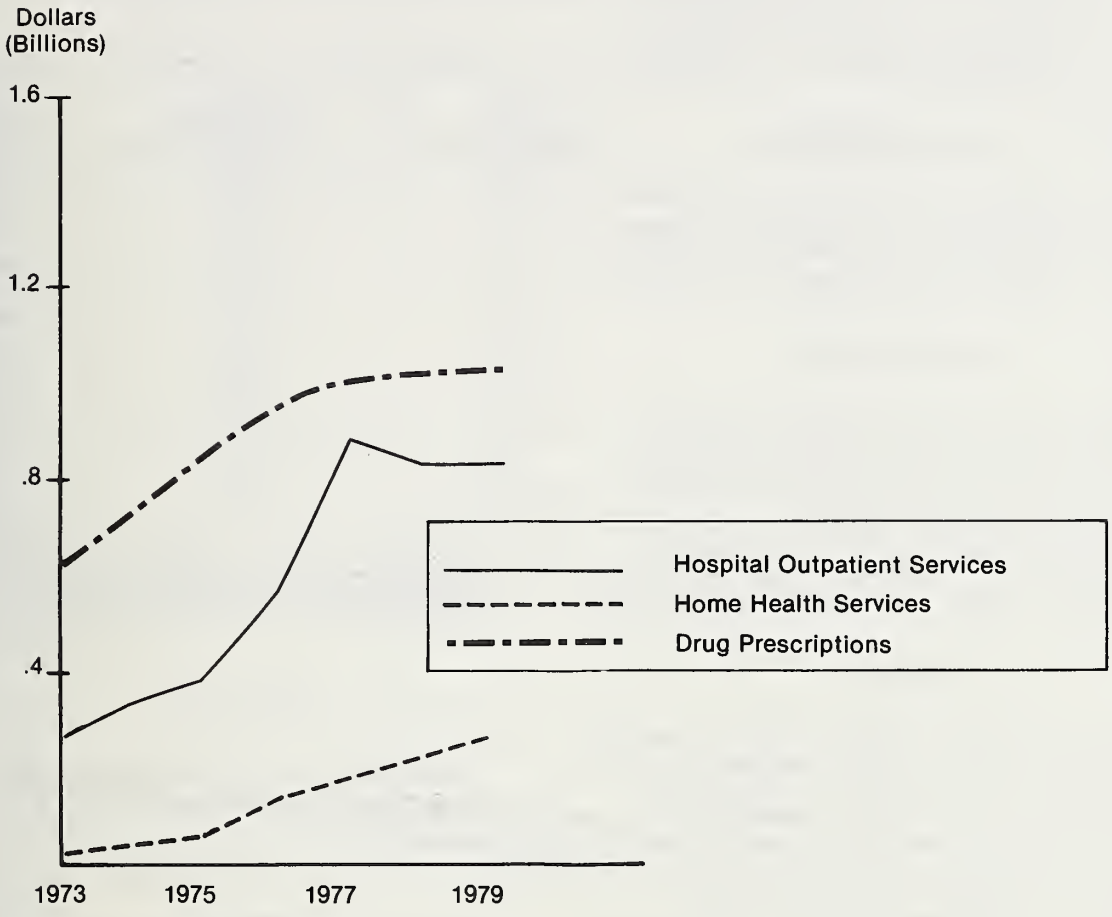
Medicaid Payments For Nursing Facility Services 1973-1979



*Scale expanded by a factor of 10 over Figure 2.2.

FIGURE 2.7

Medicaid Payments For Selected Services
1973-1979



*Vertical Scale expanded by a factor of 10 over Figure 2.2.

2. Hospital Outpatient Services

Table 2.17 reports trend data for hospital outpatient services under Medicaid between 1973 and 1979. The number of recipients grew annually from 1973 through 1977, but declined since then. Payments also peaked in 1977. However, over the whole period, payments increased more than three times faster than recipients at 19.0 percent and 5.8 percent per year, respectively.

3. Home Health Services

Data presented in Table 2.18 indicate that home health is one of the fastest growing services covered by Medicaid. Between 1973 and 1979 the number of recipients increased at an average annual rate of 19.7 percent. Payments grew at an even higher rate at 39.0 percent per year.

4. Drug Prescriptions

Table 2.19 shows data on the use of and payments for drug prescriptions under Medicaid. Both the numbers of recipients and number of prescriptions grew over the period. However, the total number of prescriptions increased more rapidly, with the result that the number of prescriptions per recipient grew at a rate of 2.9 percent per year, increasing from 10.5 in 1973 to 12.5 in 1979. Payments for prescriptions grew steadily at an annual rate of 11.3 percent (Grindstaff, et al., March 1981).[7]

5. Sterilizations

Data were collected on Federally financed sterilization procedures reported under Title XIX for calendar years 1975 through 1979. The Health Care Financing Administration obtained these data from monthly reports submitted on a routine basis by individual State Medicaid Agencies. Table 2.20 shows the total number of sterilizations reported on an annual basis. It is important to note, however, that the reporting system was implemented on July 1, 1975; thus, the 1975 annual figures do not represent the entire year.

Females had about 95 percent of all sterilizations in each year, with tubal ligation by far the most common procedure. Hysterectomies have declined considerably in volume, from 13.3 percent of female sterilizations in 1975 to 2.1 percent in 1978. Almost all male sterilizations are vasectomies.

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[7] Medicare does not cover the costs of drugs outside of an inpatient setting.

TABLE 2.17

Use of and Payments for Hospital Outpatient Services Under Medicaid, 1973-1979

Year	Recipients (thousands)	Payments (millions)
1973	5,295.4	267.6
1974	5,544.5	322.0
1975	6,157.8	377.2
1976	6,980.7	556.3
1977	8,332.7	885.2
1978	8,287.9	831.6
1979	7,505.7	836.7
ACRG (%)	5.8	19.0

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*
ACRG Annual compound rate of growth.

TABLE 2.18

Use of and Payments for Home Health Services Under Medicaid, 1973-1979

Year	Recipients (thousands)	Payments (millions)
1973	109.9	25.4
1974	134.7	31.1
1975	202.4	70.3
1976	227.2	134.3
1977	363.1	180.0
1978	358.2	209.8
1979	358.4	263.6
ACRG (%)	19.7	39.0

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations,
ACRG Annual compound rate of growth.

TABLE 2.19

Use of and Payments for Prescription Drugs Under Medicaid, 1973-1979

Year	Number of Recipients (thousands)	Number of Prescriptions (thousands)	Prescriptions Per Recipient	Payments for Prescriptions (millions)
1973	12,116.2	127,293.4	10.5	609.3
1974	13,989.4	143,179.5	10.2	712.6
1975	14,019.9	154,701.1	11.0	832.2
1976	14,336.9	170,287.8	11.9	957.0
1977	15,000.3	173,891.1	11.6	1,027.2
1978	14,736.3	176,991.2	12.0	1,084.1
1979	14,198.7	177,657.2	12.5	1,202.4
ACRG (%)	2.6	5.6	2.9	11.3

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA *National Annual Medicaid Statistics.*
ACRG Annual compound rate of growth.

TABLE 2.20

Number of Sterilizations Under Medicaid By Sex and Type of Procedure, 1975-1979

		Sex and Type of Procedure						
		Males			Females			
Year	Total Sterilizations [1]	Total	Vasectomy	Other	Total	Tubal Ligation	Hysterectomy	Other
1975 [2]	33,805	1,773	1,197	565	32,032	26,685	4,259	1,088
1976	67,575	2,709	2,684	25	64,866	57,546	3,652	3,668
1977	63,679	2,781	2,761	20	60,898	57,189	379	3,330
1978	65,775	2,787	2,763	24	62,988	57,979	1,311	3,698
1979	73,746	—	—	—	—	—	—	—

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HFCA, *National Annual Medicaid Statistics.*
[1] Not all jurisdictions report all sterilizations in every year. Thus, year-to-year fluctuations are partially due to variations in reporting.
[2] Data covers only last six months of 1975.
"---" Data not available.

F. Summary of Program Contrasts

As this chapter demonstrates, program trends in Medicare and Medicaid differ in several important ways. Although both programs have experienced a rapid growth in total reimbursements, Medicare's program expenditures have risen more rapidly, both in absolute and percentage terms. Since the inception of the programs, the number of Medicare enrolleess has been increasing, while the number of Medicaid recipients has been decreasing slightly since 1977. Given the aging patterns of our population and the contrasting program eligibility criteria, we expect that the number of Medicare enrollees will continue to increase relative to the number of Medicaid recipients.

This chapter also points out that the Medicare and Medicaid programs provide different mixes of benefits. The Medicare program is basically a program which covers acute hospital care services for the aged, whereas, the Medicaid program is becoming increasingly dominated by the provision of long-term care services.

The implications of the growth in expenditures are very different for the two programs. While both programs tend to increase the share of public spending devoted to the health care sector, the Medicaid program has a direct impact on State and local budgets. Indeed, Medicaid program expenditures represent both the largest and fastest growing component of many State budgets. The urgent State problem, in light of increasing health care expenditures, is to control Medicaid expenditures. Evolving State responses suggest that the Medicaid program may change significantly in the coming years. The Medicare program may be affected by this change to the extent that Medicare covered services would be substituted for Medicaid services. Thus program growth trends, while ostensibly independent and divergent, are likely to continue to be interrelated over time.

III. The Medicare Program: Description and Data

This chapter presents detailed information on the Medicare program. The Medicare program for financing health care for the aged was enacted on July 30, 1965, as Title XVIII of the Social Security Act. Benefits went into effect one year later, on July 1, 1966. The Medicare program (Health Insurance for the Aged) was substantially expanded by the 1972 amendments to the Social Security Act (Public Law 92-603). These amendments (effective July 1, 1973) extended Medicare coverage to disabled beneficiaries of the social security and railroad retirement programs and to persons requiring dialysis or kidney transplant for end-stage renal disease. The official name of the Medicare program was then changed to Health Insurance for the Aged and Disabled. The most recent changes to Medicare occurred with the "Omnibus Reconciliation Act of 1980" (Public Law 96-499), which became law on December 5, 1980. This law expanded certain benefits (particularly for home health care) and modified a number of reimbursement procedures and administrative practices.

The Secretary of the Department of Health and Human Services (DHHS) is responsible for the overall supervision of the Medicare program. Within DHHS, the Health Care Financing Administration (HCFA) is charged with administering the program. Medicare consists of two separate but complementary insurance programs: Hospital insurance (HI) and supplementary medical insurance (SMI). The HI program covers inpatient hospital and extended care services for persons meeting eligibility criteria, and the SMI program covers physicians' and related services for eligible persons who voluntarily pay premiums and those for whom premiums are paid. Since July 1973, most persons age 65 and over who did not meet the eligibility requirements for hospital insurance have been allowed to enroll voluntarily and pay the premiums for HI coverage if they were enrolled under the SMI program.

This section describes the eligibility standards, benefits, financing, and administration of the hospital insurance and supplementary medical insurance programs. Data are presented on HI and SMI experience in each of these areas. Detailed information on distribution of benefits is presented, wherever possible, according to the following framework:

$$\frac{\text{Persons Served}}{\text{Enrollees}} \times \frac{\text{Reimbursements}}{\text{Persons Served}} = \frac{\text{Reimbursements}}{\text{Enrollees}}$$

Where

- Persons Served are persons who exceeded applicable deductibles and were reimbursed by Medicare for services received;
- Persons Served ÷ Enrollees is the proportion of enrollees who exceeded applicable (HI or SMI) deductibles and qualified for reimbursements for covered services;
- Reimbursements ÷ Persons Served is the average amount of Medicare reimbursements paid on behalf of or to enrollees who qualified to receive Medicare reimbursements for a particular type of service;
- Reimbursement ÷ Enrollees measures the distribution of Medicare benefits within a population group.

The final sections of this chapter discuss the Medicare program's arrangements with Group Practice Prepayment Plans and Health Maintenance Organizations and describe the Medicare program's statistical systems.

A. Eligibility

All persons age 65 and over who are entitled to monthly social security cash benefits or payments from the railroad retirement system are eligible for benefits under the hospital insurance program. Effective July 1, 1973, disabled persons entitled for not less than 24 consecutive months to cash benefits under the social security or railroad retirement programs are eligible for benefits under the hospital insurance program. A person must be disabled for five months before disability benefits can begin. Medicare coverage does not begin until the 30th month after the first full calendar month of disability.

Hospital insurance protection also extends to persons who have end-stage renal disease and require renal dialysis or a kidney transplant, if they are currently insured or entitled to monthly social security benefits, or if they are the spouses or dependent children of such insured persons. Eligibility for coverage begins with the third month after a course in renal dialysis begins, or before this qualifying dialysis period for end-stage renal disease beneficiaries who receive kidney transplants without starting or receiving dialysis in preparation for transplantation. Eligibility ends with the 36th month after a person receives a kidney transplant, or after dialysis treatment has been terminated.

Under the Omnibus Reconciliation Act of 1980, unlimited enrollment periods under HI are available to the aged through the payment of a monthly premium. In 1980, this premium was set at $78. This option, however, is limited to persons who enroll in the supplementary medical insurance program.

Persons entitled to benefits under the hospital insurance program and most other persons age 65 or over may participate voluntarily in the SMI program. Only the aged can enroll for SMI without being eligible for HI; disabled persons are not permitted this option. The 1980 legislation permits Medicare beneficiaries to enroll in the SMI program at any time. An individual may decline SMI enrollment by not paying premiums, yet may reenroll at any time by resuming premium payments.[8] Entitlement begins on the third calendar month following the month of enrollment.

Under the Medicaid State buy-in system, a State government may enroll and pay SMI premiums for eligible aged and disabled individuals who are also covered by the Medicaid program.

The number of aged and disabled persons enrolled in the hospital insurance and/or supplementary medical insurance program in 1978 and 1979 are reported in Table 3.1. Total Medicare enrollees numbered almost 28 million in 1979, 90 percent of whom were aged. Over twenty-four million aged — about 95 percent of the total population age 65 and over — were enrolled in Medicare's hospital insurance program, and most HI enrollees (96 percent) were enrolled in SMI as well. Disabled enrollees in either or both programs numbered over 2.9 million in 1979. Unlike the aged, disabled persons cannot enroll in SMI without being enrolled in the HI program. Ninety-three percent of disabled HI enrollees are also enrolled in the SMI program. Over 60,000 enrollees had end-stage renal disease. Almost a third of these enrollees were age 65 or over; one-third were recipients of cash benefits for disability; and just over a third were eligible solely on the basis of end-stage renal disease.

For all categories of Medicare-eligibles, the number of enrollees was highest in the South and lowest in the West (Table 3.2). Tables 3.3 and 3.4 present detailed information on the distibution of HI and SMI benefits for aged and disabled enrollees respectively. A larger proportion of aged and disabled enrollees received benefits under the SMI program than under the hospital insurance program. For both groups, reimbursements per person served were higher under the HI program than under the SMI program. The proportions of both aged and disabled enrollees receiving benefits (number of persons served per thousand enrollees) were higher for older age groups under both the HI and SMI programs.

[8] To do so, an individual must pay a surcharge of 10 percent for every 12 months that he or she could have been enrolled.

B. Benefits

1. Overview

The hospital insurance program covers inpatient hospital care and posthospital care in skilled nursing facilities (SNFs). The program also covers home health agency services for persons confined to the home who need skilled nursing care or therapies.[9] To be covered, services must be provided by institutions and organizations that have been certified as qualified service providers and have signed agreements to participate in the program. Exceptions to this rule are made for emergency services.

The supplementary medical Insurance (SMI) program provides coverage for a variety of medical services and supplies furnished by physicians or other health care professionals in connection with physicians' services and for outpatient services provided by hospitals or clinics.

The number of institutional providers participating in the Medicare program in 1980 is reported in Table 3.5. Most of the nation's hospitals participated in Medicare, and hospitals constituted the largest class of participating providers (6,777 hospitals with over one million beds). Hospitals also absorbed the largest share of Medicare's reimbursements. As shown in Table 3.6, almost all of the HI reimbursements and 68 percent of total Medicare reimbursements went for hospital inpatient services in 1979. SMI reimbursements accounted for less than 30 percent of total reimbursements, about two-thirds of which went for physicians' services. Table 3.6 also reveals that the distribution of reimbursements differed for aged and disabled enrollees. Disabled enrollees received a smaller proportion of reimbursements under the HI program and a larger proportion of reimbursements under the SMI program than did aged enrollees.

Tables 3.7 and 3.8 present information on the distribution of specific benefits for aged and disabled enrollees respectively. In 1979, the proportion of aged enrollees receiving all listed benefits was higher for older age groups. Physicians' services were the benefits received by the largest proportion of aged enrollees, followed by outpatient and inpatient hospital services. Very small proportions of aged enrollees received SNF or home health benefits. A larger proportion of aged non-whites than aged whites received benefits for outpatient services. For all other services, larger proportions of aged whites than aged non-whites received Medicare benefits. Reimbursements per person served were higher for aged non-whites than aged whites for all except physicians' services (Ruther and Dobson, 1981). With the exception of inpatient hospital benefits, a larger proportion of aged women than aged men received benefits. For all aged enrollees, reimbursement per person served was highest for inpatient hospital services ($2,621), followed by skilled nursing facility services ($1,095), and home health agency services ($509). Reimbursements per person served for physicians' services and outpatient services were $371 and $147 respectively.

[9] Prior to the Omnibus Reconciliation Act of 1980, the HI program covered home health visits only if they followed a hospital stay. Home health visits that did not follow a hospital stay were covered by the SMI program. Coverage under each program was limited to 100 visits. The 1980 law eliminated the HI requirement for prior hospitalization and the limits on visits. Under the new law, all home health visits will be covered by the HI program unless a beneficiary has SMI coverage only. In such cases, home health visits will be covered by the SMI program.

TABLE 3.1

Number of Aged and Disabled Medicare Enrollees by Type of Coverage, As of July 1, 1978 and July 1, 1979

Type of Enrollee	Hospital Insurance and/or Supplementary Medical Insurance (thousands)		Hospital Insurance (thousands)		Supplementary Medical Insurance (thousands)	
	July 1, 1978	July 1, 1979	July 1, 1978	July 1, 1979	July 1, 1978	July 1, 1979
Total [1]	27,164.2	27,858.7	26,777.3	27,459.2	26,074.1	26,757.3
Aged [2]	24,371.0	24,948.0	23,984.1	24,548.4	23,530.9	24,098.5
Disabled [3]	2,793.2	2,910.8	2,793.2	2,910.8	2,543.2	2,658.8
ESRD – only	18.3	23.6	18.3	23.6	17.2	22.4

SOURCE: Kathryn D. Berrett "Persons Enrolled for Medicare, 1979," *Health Care Financing Notes* (Jenuery 1981), HCFA Pub. No. 03079.

[1] All enrollees aged 65 end over, including enrollees with end-stege renel diseese. Aged enrollees with HI and/or SMI with end-stage renal disease numbered 13,720 in 1978 and 17,478 in 1979.

[2] All enrollees under 65, including enrollees with end-stage renal disease. Enrollees in HI and/or SMI with end-stage renel disease who also received cash benefits for disability numbered 18,068 in 1978 end 19,532 in 1979.

[3] Persons eligible for Medicare solely because of end-stage renal disease.

The distribution of benefits for disabled enrollees was quite similar to the distribution for aged enrollees (Table 3.8). Among the disabled, however, larger proportions of non-white than white enrollees received home health as well as outpatient benefits, and reimbursements per person served were higher for non-whites than whites for all services. Larger proportions of disabled women than disabled men received all types of benefits. Reimbursements per person served were also consistently higher for disabled women than for disabled men Overall, reimbursements per person served were higher for disabled than for aged enrollees. Reimbursements for the disabled ranged from $2,952 per person served for inpatient hospital services to $421 per person served for physicians' services.

2. Benefits Under HI

The law governing the hospital insurance program establishes limits on coverage, based on the concept of a "benefit period" (or "spell of illness"). A benefit period begins with an enrollee's first day of hospitalization and ends when the enrollee has not been a bed patient in a hospital or skilled nursing facility for at least 60 consecutive days. Although there is no limit to the number of benefit periods that an enrollee may have, there are limits on covered services within each benefit period.

The hospital insurance program covers services in a participating hospital for up to 90 days in a benefit period. After an initial deductible (applicable to each benefit period), the patient is entitled to 60 days of hospitalization with no additional cost sharing. The Secretary of DHHS is required each year to determine the deductible amount, using a formula specified by law. The HI deductible amount approximates the current cost of room and board for one day in a hospital. Reflecting increases in hospital costs, the deductible has risen from $40 in 1966 to $204 in 1981. For each of the remaining 30 days in the benefit period, the patient is responsible for coinsurance equal to one-fourth of the deductible ($51 in 1981).

Each hospital insurance beneficiary also has a "lifetime reserve" of 60 additional hospital days which can be used at his or her option whenever the 90 days covered in a benefit period have been exhausted. Lifetime reserve days are subject to coinsurance equal to one-half the deductible ($102 for each lifetime reserve day in 1981).

The HI program also provides for payment to non-participating hospitals which administer emergency services to eligible patients. Under these provisions, the hospital may bill the program on an annual basis for all emergency services rendered. In the event this arrangement is unacceptable to the provider, the patient may pay for services received and submit a claim for reimbursement. These reimbursements are made according to a specified level, subject to deductible and coinsurance provisions.

Covered hospital services under HI include room and board in "semi-private" accommodations containing from two to four beds, nursing services (except for private duty nursing), drugs and biologicals, and other services ordinarily furnished by a hospital to its inpatients.[10] The HI program covers the services of physicians salaried by hospitals. Other physicians' services, including those of hospital-based specialists, are covered under SMI Hospital benefits also include reimbursement for inpatient services provided by tuberculosis hospitals and psychiatric hospitals, subject to a 190-day lifetime limit.

The hospital insurance program pays hospitals the "reasonable costs" of providing services to Medicare beneficiaries. Reasonable costs are determined after services have been delivered, according to program regulations. The Medicare statute and regulations specify the kinds of hospital costs that Medicare will recognize or allow. Medicare does not allow the costs of private duty nursing, for example; nor does it allow costs unrelated to

[10] Private accomodations are covered if medically necessary; otherwise, the patient must pay a special charge to the hospital.

TABLE 3.2

Medicare Enrollees by Type of Coverage, Census Region, and Census Division, July 1, 1979[1]

Census Region and Division	Hospital Insurance and/or Supplementary Medical Insurance			Hospital Insurance			Supplementary Medical Insurance		
	Total	Aged	Disabled[2]	Total	Aged	Disabled	Total	Aged	Disabled
All Areas	27,858,742	24,947,954	2,910,788	27,459,157	24,548,391	2,910,766	26,757,329	24,098,491	2,658,838
United States[3]	27,287,752	24,471,623	2,816,129	27,287,752	24,073,248	2,816,107	26,520,081	23,898,778	2,621,303
Northeast	6,529,701	5,905,707	623,994	6,445,155	5,882,165	623,990	6,382,937	5,785,111	577,826
New England	1,617,993	1,479,368	138,625	1,595,820	1,461,196	138,624	1,576,710	1,450,571	126,139
Middle Atlantic	4,911,708	4,426,339	485,369	4,846,335	4,360,969	485,366	4,786,207	4,334,540	451,687
North Central	7,192,156	6,532,179	659,997	7,122,090	6,462,068	659,972	7,008,428	6,397,254	611,826
East North Central	4,856,295	4,374,352	481,947	4,806,085	4,324,143	481,942	4,727,768	4,281,635	446,133
West North Central	2,335,857	2,157,827	178,030	2,315,955	2,137,925	178,030	2,280,660	2,115,619	165,041
South	8,993,368	7,938,703	1,054,665	8,816,061	7,761,403	1,054,658	8,715,693	7,729,050	986,643
South Atlantic	4,575,308	4,044,992	530,316	4,487,449	3,957,139	530,310	4,437,194	3,941,119	496,075
East South Central	1,820,847	1,580,518	240,329	1,778,528	1,538,200	240,328	1,789,473	1,542,208	227,265
West South Central	2,597,213	2,3l3,193	284,020	2,550,004	2,266,064	284,020	2,509,026	2,245,723	263,303
West	4,545,662	4,072,615	477,047	4,480,373	4,007,332	473,041	4,408,824	3,967,177	441,647
Mountain	1,112,584	1,003,300	109,284	1,099,752	990,470	109,282	1,072,001	971,877	100,124
Pacific	3,433,078	3,069,315	363,763	3,380,621	3,016,862	363,759	3,336,823	2,995,300	341,523

SOURCE: Kathryn D. Barrett, "Persons Enrolled for Medicare, 1979," *Health Care Financing Notes* (January 1981), HCFA Pub. No. 03079.

[1] Based on data recorded in Health Insurance master file on March 30, 1980.

[2] Includes enrollees under age 65 with end-stage renal disease and enrollees with end-stage renal disease only.

[3] Consists of 50 States, District of Columbia, and residence unknown.

TABLE 3.3

Persons Served and Reimbursements for Aged Medicare Enrollees by Type of Coverage, Age, Sex, Race, and Census Region, 1978

Age, Sex, Race, and Census Region	Hospital Insurance and/or Supplementary Medical Insurance			Hospital Insurance			Supplementary Medical Insurance		
	Persons Served Per 1,000 Enrollees	Reimbursements Per Person Served	Reimbursements Per Enrollee	Persons Served Per 1,000 Enrollees	Reimbursements Per Person Served	Reimbursements Per Enrollee	Persons Served Per 1,000 Enrollees	Reimbursements Per Person Served	Reimbursements Per Enrollee
Total	594	$1,456	$864	232	$2,695	$626	607	$424	$257
Age									
65–69	543	1,231	668	184	2,513	463	556	402	224
70–74	580	1,380	800	214	2,659	569	591	429	253
75–79	625	1,568	980	254	2,816	714	637	438	279
80–84	652	1,701	1,109	294	2,826	830	665	437	290
85 Years & Over	678	1,778	1,206	331	2,782	920	702	432	303
Sex									
Male	566	1,643	930	246	2,737	672	581	476	277
Female	612	1,339	819	223	2,664	594	624	391	244
Race									
White	600	1,448	869	235	2,661	626	612	423	259
Non–White	536	1,579	846	204	3,140	641	562	442	249
Region									
Northeast	638	1,523	972	219	3,206	702	645	442	285
North Central	569	1,555	884	249	2,719	676	573	384	220
South	579	1,311	760	246	2,207	543	588	400	235
West	649	1,485	964	216	3,035	656	657	496	326

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, Bennett Hirsch et al., *Medicare: Health Insurance for the Aged and Disabled, 1976-1978; Summary--Utilization and Reimbursement by Person*, in preparation.

TABLE 3.4

Persons Served and Reimbursements for Disabled Medicare Enrollees by Type of Coverage, Age, Sex, Race, and Census Region, 1978

Age, Sex, Race, and Census Region	Hospital Insurance and/or Supplementary Medical Insurance			Hospital Insurance			Supplementary Medical Insurance		
	Persons Served Per 1,000 Enrollees	Reimbursements Per Person Served	Reimbursements Per Enrollee	Persons Served Per 1,000 Enrollees	Reimbursements Per Person Served	Reimbursements Per Enrollee	Persons Served Per 1,000 Enrollees	Reimbursements Per Person Served	Reimbursements Per Enrollee
Total	527.0	$2,033	$1,071	233.5	2,982	$696	558.9	$ 737	$412
Age									
Under 35	422.6	2,586	1,093	178.2	3,497	623	445.8	1,165	519
35–44	466.2	2,292	1,069	204.1	3,093	631	495.3	977	484
45–54	508.9	2,081	1,059	230.8	2,899	669	547.5	795	435
55–59	540.4	1,938	1,047	243.8	2,897	706	577.9	652	377
60–64	597.0	1,827	1,091	262.0	2,918	765	622.2	563	350
Sex									
Male	472.1	2,017	952	216.4	2,906	629	504.7	714	360
Female	621.0	2,054	1,276	262.8	3,089	812	648.0	767	497
Race									
White	527.4	1,962	1,035	236.5	2,911	689	560.8	680	381
Non–White	512.6	2,399	1,230	212.1	3,386	718	537.3	1,037	557
Region									
Northeast	569.2	2,116	1,204	225.2	3,428	772	596.3	786	468
North Central	530.7	2,205	1,170	251.7	3,243	816	552.7	694	384
South	498.7	1,842	919	246.4	2,408	594	515.1	677	349
West	610.0	2,087	1,273	224.5	3,463	777	640.1	831	532

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, Bennett Hirsch et al., *Medicare: Health Insurance for the Aged and Disabled, 1976-1978; Summary--Utilization and Reimbursement by Person*, in preparation.

TABLE 3.5

Number and Type of Facilities Participating in the Medicare Health Insurance Program and Percentage Change, All Areas, July 1975 - July 1980

Type of Facility	Facilities						Percent Change 1975–80
	1975	1976	1977	1978	1979	1980	
Hospitals	6,773	6,802	6,806	6,797	6,801	6,777	.1
Short–Stay	6,107	6,112	6,131	6,130	6,128	6,104	–.1
Psychiatric	385	401	400	400	411	408	6.0
Other Long–Stay	238	251	239	241	244	2651	11.3
Skilled Nursing Facilities	3,932	3,928	4,002	4,749	4,963	5,052	28.5
Home Health Agencies	2,242	2,361	2,420	2,605	2,788	2,924	30.4
Independent Laboratories	3,048	3,194	3,221	3,281	3,373	3,447	13.1
	Beds						
Hospitals	1,140,395	1,149,122	1,162,990	1,142,248	1,147,498	1,149,997	.8
Short–Stay	901,757	922,601	953,067	965,323	985,070	990,621	9.9
Psychiatric	198,802	188,288	172,949	145,376	133,106	131,276	–34.0
Other Long–Stay	33,013	32,479	29,390	27,827	27,069	28,100[1]	–15.0
Skilled Nursing Facilities	287,479	309,790	349,650	418,246	419,835	436,007	51.7

SOURCE: Raymond Goldstein, "Medicare: Participating Providers and Suppliers of Health Services, 1980," *Health Care Financing Notes* (April 1981), HCFA Pub. No. 03088.

[1] Starting with this report, certified tuberculosis hospitals are now included with other long-stay hospitals. As of July 1980 only 14 tuberculosis hopsitals remained in the Medicare program.

patient care. Once a hospital's allowable costs are determined, Medicare's hospital insurance program pays the share of those costs attributable to Medicare patients.

Tables 3.9, 3.10, and 3.11 report data on the use of and reimbursements for inpatient hospital services in 1978. As shown in Table 3.9, Medicare enrollees accounted for more than 9.2 million discharges from inpatient hospitals. These discharges resulted in reimbursements of $16.1 billion dollars for almost 99.6 million covered days of care. Short-stay hospital care accounted for more than 98 percent of all discharges and reimbursements, and for over 97 percent of covered days of care. Aged enrollees, who represent 90 percent of all enrollees, used just under 90 percent of all inpatient care provided. The numbers of discharges and covered days of care per 1,000 enrollees were lower for aged than for disabled enrollees as was the average reimbursement per enrollee.

Information on the use of short-stay hospitals is presented in Tables 3.10 and 3.11 for aged and disabled enrollees, respectively. Data are broken down by age, sex, race, and region. For aged and disabled enrollees, the numbers of discharges and covered days of care per 1,000 enrollees were increasingly higher for older age groups. More aged male enrollees were discharged per thousand enrollees than were aged females. The opposite was true for disabled enrollees. In both cases, there were more discharges per 1,000 enrollees of whites than of non-whites. However, aged and disabled non-whites had more covered days of care per discharge and higher reimbursements per discharge and per covered day of care than did whites. Finally, the regional breakdowns show that the South had the greatest numbers of discharges per 1,000 enrollees for the aged, but the lowest reimbursements per discharge and per covered day of care for both groups. The Northeast had the lowest numbers of discharges per 1,000 enrollees and the highest reimbursement per discharge. The West had the highest reimbursements per covered day of care, but the fewest covered days of care per discharge. (For further discussion of geographic differences in the use of short-stay hospital services, see Gornick, 1977.)

The hospital insurance program also covers services in participating skilled nursing facilities (SNFs) for up to 100 days in a benefit period. For the first 20 days, patients face no cost-sharing obligations. The remaining 80 days are subject to coinsurance equal to one-eighth of the inpatient deductible ($25.50 in 1981). A beneficiary is eligible for SNF benefits only after hospitalization for at least three consecutive days and only if the transfer to an SNF occurs within a specified period after hospital discharge. The 1980 legislation increased that period from 14 to 30 days.

Data on the use of SNFs by aged and disabled enrollees in 1978 are reported in Tables 3.12 and 3.13. Information on persons served and reimbursements are broken down by age, sex, race, and region for each type of enrollee. Overall, the proportion of the elderly who received SNF benefits was much higher than the proportion of the disabled who received SNF benefits—11.1 persons served per 1,000 aged enrollees compared to 3.3 per 1,000 disabled enrollees. Reimbursements per person served, however, were almost 20 percent higher for disabled beneficiaries

TABLE 3.6

Medicare Reimbursements by Type of Enrollee, Type of Coverage, and Type of Service, Fiscal Year 1979

Coverage and Type Of Service	All Enrollees		Aged		Disabled	
	Reimbursements (millions)	Percent	Reimbursements (millions)	Percent	Reimbursements (millions)	Percent
Hospital Insurance and/or Supplementary Medical Insurance	$28,150	100.00%	$24,383	100.00%	$3,767	100.00%
Hospital Insurance (Part A)	19,891	70.67	17,490	71.73	2,401	63.74
Hospital Inpatient Services	19,079	67.78	16,724	68.59	2,355	62.52
Skilled Nursing Facility Services	368	1.31	355	1.46	13	0.35
Home Health Services	444	1.58	411	1.69	33	0.88
Supplementary Medical Insurance (Part B)	8,259	29.33	6,893	28.27	1,366	36.26
Physicians' Services	5,841	20.75	5,161	21.17	680	18.05
Hospital Outpatient Services	1,555	5.52	950	3.90	605	16.06
Home Health Services	190	0.67	175	0.72	15	0.40
Other Medical Services	673	2.39	607	2.49	66	1.75

SOURCE: Office of Research, Demonstrations, and Statistics, HCFA, unpublished data.

TABLE 3.7

Persons Served and Reimbursements for Aged Medicare Enrollees by Type of Coverage, Type of Service, Age, Sex, Race, and Census Region, 1978

Age, Sex, Race, and Census Region	Hospital Insurance						Supplementary Medical Insurance		
	Inpatient Hospital Services			Skilled Nursing Facility Services			Physician and Other Medical Services		
	Persons Served Per 1,000 Enrollees [2]	Reimbursements Per Person Served	Reimbursements Per Enrollee	Persons Served Per 1,000 Enrollees [2]	Reimbursements Per Person Served	Reimbursements Per Enrollee	Persons Served Per 1,000 Enrollees [2]	Reimbursements Per Person Served	Reimbursements Per Enrollee
Total	230	$2,621	$602	11	$1,095	$12	589	$371	$219
Age									
65–69	183	2,472	452	3	1,213	4	536	348	187
70–74	212	2,598	552	7	1,126	7	574	371	213
75–79	250	2,734	685	12	1,124	14	620	389	241
80–84	289	2,724	787	22	1,086	24	649	389	253
85 Years & Over	324	2,659	862	35	1,025	36	684	380	260
Sex									
Male	243	2,680	652	9	1,039	9	563	421	237
Female	220	2,576	567	13	1,123	14	607	340	206
Race									
White	233	2,586	602	12	1,087	13	597	374	223
Non–White	201	3,062	615	8	1,256	10	521	348	182
Region									
Northeast	215	3,120	671	11	1,316	14	620	382	237
North Central	246	2,654	654	12	1,100	13	555	338	188
South	244	2,144	523	8	1,034	8	575	355	204
West	214	2,937	628	17	947	16	643	430	276

(continued)

TABLE 3.7 (continued)
Persons Served and Reimbursements for Aged Medicare Enrollees by Type of Coverage, Type of Service, Age, Sex, Race, and Census Region, 1978

Age, Sex, Race, and Census Region	Supplementary Medical Insurance: Outpatient Services: Persons Served Per 1,000 Enrollees [2]	Supplementary Medical Insurance: Outpatient Services: Reimbursements Per Person Served	Supplementary Medical Insurance: Outpatient Services: Reimbursements Per Enrollee	Hospital Insurance and/or Supplementary Medical Insurance: Home Health Agency Services [1]: Persons Served Per 1,000 Enrollees [2]	Hospital Insurance and/or Supplementary Medical Insurance: Home Health Agency Services [1]: Reimbursements Per Person Served	Hospital Insurance and/or Supplementary Medical Insurance: Home Health Agency Services [1]: Reimbursements Per Enrollee
Total	231	$147	$34	33	$509	$17
Age						
65–69	218	160	35	17	511	8
70–74	227	160	36	26	533	14
75–79	238	136	32	40	512	20
80–84	243	124	30	54	492	27
85 Years & Over	257	123	32	68	495	34
Sex						
Male	225	160	36	29	503	15
Female	235	139	33	36	512	18
Race						
White	229	138	32	33	500	16
Non–White	260	230	60	28	579	23
Region						
Northeast	283	155	44	45	471	21
North Central	221	130	29	26	460	12
South	194	132	26	30	567	17
West	250	182	45	32	510	16

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, Bennett Hirsch et al., *Medicare: Health Insurance for the Aged and Disabled, 1976-1978; Summary--Utilization and Reimbursement by Person,* in preparation.

[1] Data on home health agency services for 1978 reflect program characteristics prior to the 1980 Omnibus Reconciliation Act. For a description of these characteristics and the changes made by the 1980 law, see footnote 9 in text.

[2] The number of persons served represent those enrollees reimbursed for one or more covered services.

TABLE 3.8

Persons Served and Reimbursements for Disabled Medicare Enrollees by Type of Coverage, Type of Service, Age, Sex, Race, and Census Region, 1978

Age, Sex Race, and Census Region	Hospital Insurance						Supplementary Medical Insurance		
	Inpatient Hospital Services			Skilled Nursing Facility Services			Physician and Other Medical Services		
	Persons Served Per 1,000 Enrollees [1]	Reimbursements Per Person Served	Reimbursements Per Enrollee	Persons Served Per 1,000 Enrollees [1]	Reimbursements Per Person Served	Reimbursements Per Enrollee	Persons Served Per 1,000 Enrollees [1]	Reimbursements Per Person Served	Reimbursements Per Enrollee
Total	231.5	$2,952	$683	3.3	$1,310	$4	519.2	$421	$219
Age									
Under 35	177.4	3,481	618	1.1	1,543	2	399.4	491	196
35–44	202.8	3,073	623	1.6	1,380	2	452.7	460	208
45–54	229.1	2,873	658	2.4	1,402	3	507.3	432	219
55–59	241.6	2,864	692	3.6	1,288	5	540.7	412	223
60–64	259.1	2,880	746	5.3	1,261	7	585.0	391	229
Sex									
Male	214.5	2,886	619	2.7	1,291	4	464.7	420	195
Female	260.6	3,045	794	4.3	1,330	6	608.8	424	258
Race									
White	234.7	2,881	676	3.4	1,267	4	526.6	420	221
Non–White	209.6	3,361	704	2.6	1,582	4	470.9	431	203
Region									
Northeast	222.5	3,388	754	3.2	1,541	5	539.4	426	230
North Central	249.8	3,216	803	4.1	1,357	6	514.6	393	202
South	244.7	2,386	584	2.3	1,161	3	482.5	402	194
West	222.7	3,424	763	5.1	1,222	6	603.3	488	294

(continued)

TABLE 3.8 (continued)

Persons Served and Reimbursements for Disabled Medicare Enrollees by Type of Coverage, Type of Service, Age, Sex, Race, and Census Region, 1978

Age, Sex, Race, and Census Region	Supplementary Medical Insurance			Hospital Insurance and/or Supplementary Medical Insurance		
		Outpatient Services			Home Health Agency Services [2]	
	Persons Served Per 1,000 Enrollees [1]	Reimbursements Per Person Served	Reimbursements Per Enrollee	Persons Served Per 1,000 Enrollees [1]	Reimbursements Per Person Served	Reimbursements Per Enrollee
Total	284.5	$ 664	$189	22.3	$580	$13
Age						
Under 35	270.5	1,184	320	11.3	617	7
35–44	283.6	959	272	15.4	647	10
45–54	292.0	725	212	19.4	600	12
55–59	286.5	523	150	24.3	582	14
60–64	283.4	411	116	30.2	550	17
Sex						
Male	255.6	634	162	17.0	551	9
Female	331.9	702	233	31.3	606	19
Race						
White	276.2	564	156	21.6	581	13
Non–White	323.1	1,082	350	25.4	582	15
Region						
Northeast	332.6	701	233	31.8	592	19
North Central	277.8	639	178	20.3	548	11
South	241.7	625	151	18.6	580	11
West	342.1	684	234	22.0	566	12

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, *Medicare: Health Insurance for the Aged and Disabled, 1976-1978; Summary--Utilization and Reimbursement by Person,* in preparation.

[1] The number of persons served represent those enrollees reimbursed for one or more covered services.

[2] Data on home health agency services for 1978 reflect program characteristics prior to the 1980 Omnibus Reconciliation Act. For a description of these characteristics and the changes made by the 1980 law, see footnote, p. 62.

TABLE 3.9

Use of and Reimbursements for Inpatient Hospitals by Medicare Enrollees, by Type of Enrollee and Type of Hospital, 1978

Type of Facility	Discharges		Covered Days of Care			Reimbursements			
	Number (thousands)	Per 1,000 Enrollees	Number (thousands)	Per Discharge	Per 1,000 Enrollees	Total Amount (millions)	Per Discharge	Per Covered Day of Care	Per Enrollee
All Enrollees									
Total Inpatient	9,247.2	345.3	99,597.4	10.8	3,720	$16,119.6	$1,743	$162	$601.98
Short-Stay	9,134.0	341.1	96,847.0	10.6	3,617	15,869.4	1,737	164	592.64
Long-Stay [1]	113.2	4.2	2,750.4	24.3	103	250.2	2,210	91	9.34
Psychiatric	65.0	2.4	1,589.2	24.5	59	108.6	1,671	68	4.05
All Other	48.2	1.8	1,161.2	24.1	44	141.6	2,938	122	5.29
Aged Enrollees									
Total Inpatient	8,153.6	340.0	88,081.5	10.8	3,672	14,229.0	1,745	162	593.27
Short-Stay	8,085.2	337.1	86,398.0	10.7	3,602	14,062.4	1,739	163	586.32
Long-Stay [1]	68.4	2.9	1,683.5	24.6	70	166.6	2,436	99	6.95
Psychiatric	30.0	1.3	754.0	25.2	31	54.5	1,817	72	2.27
All Other	38.4	1.6	929.5	24.2	39	112.1	2,919	121	4.68
Disabled Enrollees									
Total Inpatient	1,093.6	391.5	11,515.9	10.5	4,123	1,890.6	1,729	164	676.86
Short-Stay	1,048.8	375.5	10,449.0	10.0	3,741	1,807.0	1,723	173	646.93
Long-Stay [1]	44.8	16.0	1,066.9	23.8	382	83.6	1,866	78	29.93
Psychiatric	35.0	12.5	843.3	24.0	302	54.7	1,563	65	19.58
All Other	9.8	3.5	223.6	22.9	80	28.9	2,949	129	10.35

SOURCE: Medicare Program Statistics Branch, unpublished data.

[1] Excludes discharges with zero covered days of care.

TABLE 3.10

Use of Short-Stay Hospitals by Aged Medicare Enrollees, by Age, Sex, Race, and Census Region, 1978[1]

Age, Sex, Race, and Census Region	Number of Aged Hospital Insurance Enrollees (thousands)	Discharges		Covered Days of Care			Reimbursements			
		Number (thousands)	Per 1,000 Enrollees	Number (thousands)	Per Discharge	Per 1,000 Enrollees	Per Covered Day of Care	Per Discharge	Total Amount (millions)	Per Enrollee
Total	23,984	8,147	340	87,535	10.7	3,650	$13,967	$1,714	$162	$582
Age										
65–66	3,366	887	263	8,686	9.8	2,581	1,439	1,622	169	428
67–68	3,124	840	269	8,333	9.9	2,667	1,382	1,645	168	442
69–70	2,902	840	290	8,459	10.1	2,915	1,388	1,652	166	478
71–72	2,576	806	313	8,339	10.3	3,237	1,364	1,692	166	530
73–74	2,291	769	336	8,129	10.6	3,549	1,312	1,706	164	573
74–79	4,537	1,707	376	18,786	11.0	4,141	2,992	1,753	162	659
80–84	2,997	1,279	427	14,704	11.5	4,906	2,271	1,776	158	758
85 & Over	2,191	1,019	465	12,099	11.9	5,522	1,818	1,784	155	830
Sex										
Male	9,728	3,595	370	37,446	10.4	3,849	6,162	1,714	167	633
Female	14,256	4,552	319	50,090	11.0	3,514	7,805	1,715	159	547
Race[2]										
White	21,289	7,347	345	78,071	10.6	3,667	12,423	1,691	162	584
Non–White	2,036	596	293	7,250	12.2	3,562	1,196	2,007	169	587
Region[3]										
Northeast	5,730	1,739	304	22,998	13.2	4,013	3,676	2,114	166	642
North Central	6,361	2,318	364	25,346	10.9	3,985	4,012	1,731	161	631
South	7,530	2,804	372	27,761	9.9	3,687	3,886	1,386	141	516
West	3,882	1,228	316	10,817	8.8	2,786	2,348	1,912	220	605

SOURCE: From Martin Ruther, "Medicare: Inpatient Utilization of Short-Stay Hospitals by the Aged and Disabled Under Medicare: Annual Summary, 1978," HCFA (in preparation).

[1] The data differ from those reported in Table 3.9, which is based on a slightly earlier date of processing.

[2] Excludes persons of unknown race.

[3] Excludes Puerto Rico and other outlying areas.

TABLE 3.11

Use of Short-Stay Hospitals by Disabled Medicare Enrollees, by Age, Sex, Race, and Census Region, 1978[1]

Age, Sex, Race, and Census Region	Number of Disabled Hospital Insurance Enrollees (thousands)	Discharges		Covered Days of Care			Reimbursements			
		Number (thousands)	Per 1,000 Enrollees	Number (thousands)	Per Discharge	Per 1,000 Enrollees	Total Amount (millions)	Per Discharge	Per Covered Day of Care	Per Enrollee
Total [2]	2,793	1,061	380	10,638	10.0	3,809	$1,788	$1,685	$172	$640
Age										
Under 35	345	101	294	1,032	10.2	2,993	191	1,891	193	554
35–44	335	114	341	1,100	9.6	3,280	185	1,623	175	552
45–54	647	249	385	2,384	9.6	3,687	397	1,594	171	614
55–59	609	243	398	2,459	10.1	4,038	408	1,679	170	670
60–64	857	354	413	3,664	10.4	4,273	606	1,712	169	707
Sex										
Male	1,763	621	352	6,034	9.7	3,423	1,020	1,643	174	579
Female	1,030	440	427	4,604	10.5	4,469	768	1,745	171	746
Race										
White	2,299	895	389	8,809	9.8	3,832	1,463	1,635	170	636
Non-White	448	146	326	1,610	11.0	3,596	288	1,973	183	643
Region										
Northeast	597	208	348	2,503	12.0	4,194	416	2,000	172	697
North Central	642	264	412	2,813	10.7	4,381	483	1,830	177	752
South	1,006	411	409	3,799	9.2	3,778	551	1,341	147	548
West	457	170	372	1,444	8.5	3,158	329	1,935	235	720

SOURCE: Martin Ruther, "The Use of Short-Stay Hospital Services by the Aged and Disabled Medicare Enrollees, 1978," HCFA (2n preparation).

[1] The data differ from those reported in Table 3.9, which is based on a slightly earlier date of processing.

[2] Includes persons of unknown race and residence, and persons residing outside the 50 states and the District of Columbia.

than for aged beneficiaries. For both aged and disabled enrollees, the number of persons served as well as total reimbursements were higher for older age groups, while reimbursements per person served were generally lower for older age groups. Proportionately more females than males received SNF benefits, and females also received higher reimbursements per person served than did males among both aged and disabled enrollees. There were higher rates of whites among persons served per 1,000 enrollees than of non-whites. However, reimbursements per person served were about 25 percent higher for non-whites than for whites. These patterns were true for both aged and disabled enrollees. The rates of persons served per 1,000 Medicare enrollees were lowest in the South and highest in the West. Total reimbursements and reimbursements per person served were lower in the South and West than in the Northeast and North Central regions for both aged and disabled enrollees.

The third type of benefit covered by the hospital insurance program is home health services for persons confined to the home and needing part-time or intermittent skilled nursing care or therapies. Covered services include skilled nursing care; physical, occupational or speech therapy; part-time or intermittent services of a home health aide; medical supplies (other than drugs and biologicals); the use of medical appliances; and, in certain cases, services of an intern or resident. The services must be furnished by or under arrangements with an approved home health agency.

Table 3.14 presents data on the use of home health services in 1978.[11] In contrast to other tables in this chapter, these data include information on all users, not just those who satisfied the deductible. The number of users per 1,000 enrollees was almost 50 percent greater for aged enrollees than for the disabled. However, reimbursements per user were about 16 percent higher for disabled ($646), than for aged users ($559). Among aged enrollees, a higher proportion of those 75 and over use home health services than those under 75. Enrollees who were 75 or older represented only 36 percent of all Medicare enrollees, but they accounted for 57 percent of all reimbursements for home health services. Comparisons by sex and race show that higher proportions of females and non-whites used home health services than did males and whites, respectively.[12] In addition, reimbursements per user were higher for females and non-whites than they were for males and whites.

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[11] These data include services and reimbursements paid for under the supplementary medical insurance program. See footnote [9].

[12] In addition to describing differences in the use of health services by demographic characteristics, the paper by Silverman cited in Table 3.14 discusses the patterns of services rendered by the different types of home health agencies.

TABLE 3.12

Use of Skilled Nursing Facilities by Aged Medicare Enrollees, by Age, Sex, Race, and Census Region, 1978

Age, Sex, Race, and Census Region	Number of Aged Hospital Insurance Enrollees [1] (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total [2]	23,984.1	267.3	11.1	$292.8	$1,095	$12.21
Age						
65–69	7,956.9	26.9	3.4	32.6	1,213	4.10
70–74	6,302.0	41.0	6.5	46.2	1,126	7.32
75–79	4,536.5	56.2	12.4	63.2	1,124	13.92
80–84	2,997.4	66.7	22.2	72.4	1,086	24.15
85 & Over	2,191.1	76.6	34.9	78.5	1,025	35.80
Sex						
Male	9,727.7	88.0	9.0	91.4	1,039	9.39
Female	14,256.3	179.3	12.6	201.4	1,123	14.13
Race [3]						
White	21,289.1	245.1	11.5	266.3	1,087	12.15
Non-White	2,035.7	15.5	7.6	19.4	1,256	9.55
Region						
Northeast	5,730.4	61.0	10.6	80.2	1,316	14.00
North Central	6,360.9	77.4	12.2	85.1	1,100	13.39
South	7,529.8	61.8	8.2	63.9	1,034	8.49
West	3,881.9	66.7	17.2	63.1	947	16.27

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, *Medicare: Health Insurance for the Aged and Disabled, 1976-1978; Summary--Utilization and Reimbursement by Person,* in preparation.

[1] As of July 1, 1978.

[2] Includes persons of unknown age.

[3] Excludes persons of unknown race.

TABLE 3.13

Use of Skilled Nursing Facilities by Disabled Medicare Enrollees, by Age, Sex, Race, and Census Region, 1978

Age, Sex, Race, and Census Region	Number of Disabled Hospital Insurance Enrollees [1] (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total [2]	2,793.2	9.2	3.3	$12.0	$1,310	$4.30
Age						
Under 35	344.8	0.4	1.1	0.6	1,543	1.74
35–44	335.4	0.5	1.6	0.7	1,380	2.09
45–54	646.5	1.6	2.4	2.2	1,402	3.40
55–59	609.0	2.2	3.6	2.8	1,288	4.60
60–64	857.5	4.5	5.3	5.7	1,261	6.65
Sex						
Male	1,763.0	4.8	2.7	6.2	1,291	3.52
Female	1,030.2	4.4	4.3	5.9	1,330	5.73
Race [3]						
White	2,299.1	7.8	3.4	9.8	1,267	4.26
Non-White	447.8	1.2	2.6	1.9	1,582	4.24
Region						
Northeast	596.9	1.9	3.2	2.9	1,541	4.86
North Central	642.0	2.6	4.1	3.5	1,357	5.45
South	1,005.5	2.3	2.3	2.7	1,161	2.69
West	457.2	2.3	5.1	2.8	1,222	6.12

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, *Medicare: Health Insurance for the Aged and Disabled, 1976-1978; Summary--Utilization and Reimbursement by Person*, in preparation.

[1] As of July 1, 1978.

[2] Includes persons of unknown age.

[3] Excludes persons of unknown race.

3. Benefits Under SMI

The SMI program covers physicians' services, including visits to the home, office, hospital, and other institutions. The program also pays for other services and supplies, such as drugs and biologicals that cannot be self-administered, if they are furnished as a part of a physician's professional services; diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests; X-rays, radium, and radioactive isotope therapy; splints, casts, and other devices used for reduction of fractures and dislocations; purchase or rental of durable medical equipment; ambulance services; and prosthetic devices that replace all or part of a body organ. In addition, the SMI program pays for outpatient services received in hospitals, rural health centers, community health centers, and renal dialysis centers; outpatient rehabilitation, and speech and physical therapy services. Effective July 1, 1973, the 1972 amendments provided for coverage of services of a physical therapist in independent practice furnished in his or her office or the patient's home, if under a physician's plan. The reimbursement limit for these services was increased from $100 to $500 by the 1980 Omnibus Reconciliation Act. Finally, limited chiropractic and optometric services are also covered.

During each calendar year, the established deductible must be satisfied before payment can be made under the SMI program. Since 1973, the annual deductible has been $60. Incurred rather than paid charges count toward the deductible, at amounts the program deems reasonable. Medical expenses incurred in the last three months of a year can be "carried over" to the following year's deductible.

After the deductible has been met, the SMI program pays for 80 percent of the reasonable charges for covered physicians' services and most other medical services. The reasonable charge, on which the Medicare SMI payment is based, may not exceed the lowest of (1) the service provider's customary charge for the service, (2) the prevailing charge in the locality for similar services, or (3) the charge applicable for comparable services under comparable circumstances to the policyholders or subscribers of the carrier. Since 1973, annual increases in prevailing charges have been limited by an economic index which reflects increases in providers' expenses and increases in general earnings. On each claim for payment, physicians can accept or reject assignment. Acceptance of assignment means that the physician submits the bill and agrees to accept the amount Medicare deems reasonable as full payment for the services. Physicians who do not accept assignment may bill patients for charges above the Medicare-determined reasonable charge.

TABLE 3.14

Users of and Reimbursments for Home Health Agency Services: Medicare Enrollees by Type, Age, Sex, and Race, 1978

Type, Age, Sex, and Race	Number of Enrollees (thousands)	Users		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per User	Per Enrollee
Total	27,164	769.7	28.3	$435.3	$566	$16.00
Type of Enrollee						
Aged	24,371	713.1	29.3	398.7	559	16.40
Disabled	2,793	56.6	20.3	36.6	646	13.10
Age						
Under 65	2,793	56.6	20.3	36.6	646	13.10
65–74	14,607	266.5	18.2	150.4	564	10.30
75 & over	9,764	446.6	45.7	248.3	556	25.40
Sex						
Male	11,598	280.9	24.2	156.4	557	13.50
Female	15,566	488.7	31.4	278.9	571	17.90
Race						
White	23,866	666.7	27.9	370.7	556	15.50
Non–White	2,570	84.0	32.1	54.2	645	21.10
Unknown	727	18.9	26.0	10.4	549	14.30

SOURCE: Herbert A. Silverman, "Utilization of Home Health Services: 1978," *Medicare Program Statistics Report,* HCFA (in press).

Deductible and coinsurance requirements do not apply to hospital-based radiologists and pathologists accepting assignment for services furnished to hospital inpatients. For these services, reasonable charges are reimbursed in full by Medicare.

The charges of independent laboratories which are assigned by the provider are paid at 100 percent of the rate negotiated between DHHS and the specific laboratory, with the deductible and coinsurance requirements being waived. Hospital services incidental to outpatient care are subject to the SMI deductible and coinsurance, but, like hospital services covered under the HI program, are reimbursed on the basis of reasonable costs. Outpatient treatment for mental illness is also subject to the deductible and coinsurance and benefits are also limited to the lesser of 50 percent of reasonable charges or $250.

Table 3.15 reports data on charges and reimbursement rates per enrollee for benefits covered by SMI. Data are presented for each year from 1967 through 1978 by type of enrollee. Reimbursements are estimated by subtracting applicable deductibles and coinsurance amounts from reasonable costs or charges for each enrollee. Charges to enrollees that exceed amounts the program deems reasonable are not included. These charges would, nevertheless, represent liabilities to beneficiaries whose physicians do not accept assignment.

In 1978, Medicare reimbursements under SMI covered approximately 72 percent of the reasonable costs or charges of all covered services for both aged and disabled enrollees. In 1967, the program reimbursed 57 percent of reasonable costs or charges to aged enrollees. In that year, reasonable costs or charges were $110.32 per enrollee, and reimbursements were $63.16 per enrollee. In 1974 (the first full year of coverage for the disabled), Medicare reimbursed 66 percent of reasonable costs or charges to the disabled. Reasonable costs or charges were $180.52 per disabled enrollee, and reimbursements were $119.81 per enrollee. By 1978, reasonable costs or charges for both the aged and disabled had risen to about $354 per enrollee; reimbursements had risen to more than $253 per enrollee. Physicians' services represent the major share, about 75 percent, of services reimbursed by SMI in 1978. The proportion of reasonable charges reimbursed for physicians' services in 1978 was only slightly lower than the proportion reimbursed for all services. Inpatient radiology and pathology services and home health agency services had higher than average proportions of reasonable costs or charges reimbursed, reflecting the limited cost sharing applicable to these services.

TABLE 3.15

Supplementary Medical Insurance Charges and Reimbursement Rates Per Enrollee by Type of Service and Enrollee Group, 1967-1978

Year Ending 6/30	Average Enrollment (thousands)	All Services[1]		Physicians' Services[2]		Inpatient Radiology & Pathology Services[3]		Outpatient Services		Home Health Agency Services		Group Practice Prepayment Plan Services		Independent Laboratory Services	
		Reasonable Cost or Charge	Reimbursement	Reasonable Cost or Charge	Reimbursement	Reasonable Cost or Charge	Reimbursement	Reasonable Cost or Charge	Reimbursement	Reasonable Cost or Charge	Reimbursement	Reasonable Cost or Charge	Reimbursement	Reasonable Cost or Charge	Reimbursement
Aged Enrollees															
1967	17,750	$110.32	$63.16	$103.20	$59.09	NA[4]	NA[4]	$ 2.46	$ 1.41	$ 1.38	$0.79	$2.87	$1.64	$0.41	$0.23
1968	18,038	128.27	80.21	117.07	72.56	$ 1.89	$1.89	3.88	2.40	2.41	1.49	2.46	1.52	0.56	0.35
1969	18,833	145.86	93.85	126.15	79.05	6.57	6.57	6.74	4.22	3.06	1.92	2.70	1.69	0.64	0.40
1970	19,312	154.10	100.04	131.01	82.82	7.14	7.14	9.38	5.93	3.15	1.99	2.66	1.68	0.76	0.48
1971	19,664	162.61	106.33	137.64	87.78	7.21	7.21	11.85	7.56	2.63	1.68	2.33	1.49	0.95	0.61
1972	20,043	173.09	114.06	146.97	94.81	6.77	6.77	13.29	8.57	2.49	1.61	2.36	1.52	1.21	0.78
1973	20,428	186.60	122.42	157.31	100.89	6.99	6.99	14.72	9.44	3.08	2.22	3.03	1.94	1.47	0.94
1974	20,988	204.42	134.38	171.06	109.87	7.43	7.43	17.67	11.35	2.64	2.12	3.76	2.42	1.86	1.19
1975	21,504	235.38	159.14	191.83	126.64	8.69	8.69	23.44	15.47	4.83	3.99	4.14	2.73	2.45	1.62
1976	22,089	270.17	186.91	213.62	144.15	10.84	10.84	31.53	21.28	6.37	5.37	4.87	3.24	2.94	1.98
1977	22,605	310.11	218.67	239.34	164.81	12.15	12.15	41.65	28.68	7.82	6.73	5.72	3.94	3.43	2.36
1978	23,133	353.57	253.21	271.96	190.24	14.71	14.71	47.76	33.42	8.02	7.01	7.12	4.98	4.00	2.80
Disabled Enrollees (excluding ESRD-only enrollees)															
1974	1,647	180.52	119.01	139.56	89.48	7.50	7.50	21.56	13.82	4.47	3.58	6.37	4.78	0.86	0.55
1975	1,828	218.70	148.75	174.61	115.43	8.33	8.33	25.93	17.22	4.45	3.69	3.82	2.54	1.56	1.04
1976	2,033	254.85	177.44	200.49	136.28	9.85	9.85	31.52	21.43	6.19	5.26	4.74	3.22	2.06	1.40
1977	2,248	304.20	216.61	227.40	158.30	12.73	12.73	51.77	36.04	5.61	4.88	4.11	2.86	2.58	1.80
1978	2,440	354.15	256.16	264.89	187.64	14.22	14.22	59.43	42.10	6.41	5.69	5.70	4.04	3.50	2.48

SOURCE: The Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1980 Annual Report,* June 17, 1980, pp. 39-40.

[1] The figures here may vary rom those presented in other tables in this report., these estimates generated by the actuarial department from a 0.1% sample of all aged and 1.0% sample of all disabled enrollees. Reimbursements are estimated by subtracting applicable deductibles and coinsurance amounts from reasonable costs on charges for each enrollee. Charges to enrollees that exceed amounts the program deems reasonable are not included.

[2] These figures vary from those presented in Tables 3.16 and 3.17 for the reason given in note 1 and because Tables 3.14 and 3.15 provide figures for physicians' and other medical services while these figures are for physicians' services only.

[3] Includes services on payment records and those using combined billing: amounts shown are for April 1968 and later, when combined billings are authorized and inpatient radiology and pathology charges are reimbursed at 100%.

[4] Inpatient radiology and pathology services were reimbursed by the HI program prior to April 1, 1968.

NA Not applicable.

Tables 3.16 and 3.17 provide data on the use of physicians' and other medical services in 1978 by aged and disabled enrollees, respectively. The number of persons served per 1,000 enrollees was slightly higher for aged enrollees (589) than for disabled enrollees (519). However, reimbursement per person served was higher for disabled enrollees ($421 versus $371), with the result that reimbursements per enrollee were almost identical for both aged and disabled enrollees (about $219 per enrollee). For both types of enrollees, the numbers of persons served per 1,000 enrollees were higher for older age groups. With the exception of the oldest age group, reimbursement per person served also was higher for older than for younger aged enrollees. The reverse was true for disabled enrollees. Proportionately more women than men received benefits in both enrollee groups, although reimbursement per person served was about 20 percent lower for aged female enrollees than for aged male enrollees. Among disabled enrollees, reimbursements per person served were very similar for both men and women. The number of persons served per 1,000 enrollees was higher for whites than for non-whites in both enrollment groups. Reimbursement per person served was higher for aged whites than for aged non-whites. The opposite was true among disabled persons served. Data by region show that aged and disabled enrollees living in the West had both the highest rates of persons served per 1,000 enrollees and the highest amounts reimbursed per person served. Aged enrollees residing in the North Central region had the lowest rate of persons served per 1,000 enrollees and amount reimbursed per person served.

Table 3.18 reports data for 1978 on the number of physicians' services used and the charges for those services (Medicaid Statistical Files Manual, I978).[13] The numbers of services used and total charges were highest in the South for both aged and disabled enrollees. However, the charges per service were lowest in the South for both aged and disabled enrollees. The highest charges per service occurred in the Northest for aged enrollees and in the West for disabled enrollees. With the exception of the Northeast, disabled enrollees had a slightly higher charge per service than aged enrollees in every region.

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[13] "A service is defined as a procedure having a separate reasonable charge determination" (Medicare Statistical Files Manual, HCFA Pub. No. 018, 4-78, p. 149).

TABLE 3.16

Use of Physicians' and Other Medical Services by Aged Medicare Enrollees, by Age, Sex, Race, and Census Region, 1978

Age, Sex, Race, and Census Region	Number of Aged Supplementary Medical Insurance Enrollees [1] (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total	23,530.9	13,862.1	589.1	$ 5,145.1	$371.16	$218.65
Age						
65–69	7,835.7	4,199.9	536.0	1,462.4	348.20	186.64
70–74	6,283.2	3,608.5	574.3	1,340.3	371.43	213.32
75–79	4,427.4	2,745.9	620.2	1,067.2	388.67	241.05
80–84	2,902.2	1,883.1	648.9	733.4	389.47	252.71
85 & over	2,082.4	1,424.6	684.1	541.7	380.23	260.12
Sex						
Male	9,436.5	5,308.0	562.5	2,236.0	421.25	236.95
Female	14,094.4	8,554.0	606.9	2,909.1	340.08	206.40
Race [2]						
White	20,906.4	12,469.8	596.5	4,658.8	373.61	222.84
Non–White	1,978.0	1,031.2	521.4	359.2	348.28	181.58
Region						
Northeast	5,689.8	3,525.9	619.7	1,347.4	382.15	236.81
North Central	6,293.9	3,494.6	555.2	1,182.7	338.44	187.91
South	7,495.7	4,306.0	574.5	1,530.7	355.47	204.21
West	3,843.6	2,469.4	642.5	1,062.7	430.33	276.48

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, *Medicare: Health Insurance for the Aged and Disabled, 1976-1978; Summary--Utilization and Reimbursement by Person,* in preparation.

[1] As of July 1, 1978.

[2] Excludes persons of unknown race.

TABLE 3.17

Use of Physicians' and Other Medical Services by Disabled Medicare Enrollees, by Age, Sex, Race, and Census Region, 1978

Age, Sex, Race, and Census Region	Number of Disabled Supplementary Medical Insurance Enrollees [1] (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total	2,543.2	1,320.3	519.2	$556.5	$421.49	$218.82
Age						
Under 35	311.9	124.5	399.4	61.2	491.49	196.22
35–44	303.1	137.2	452.7	63.1	459.67	208.18
45–54	579.2	293.8	507.3	127.0	432.17	219.27
55–59	550.9	297.9	540.7	122.7	411.74	222.73
60–64	798.1	466.9	585.0	182.6	391.10	228.79
Sex						
Male	1,581.8	735.0	464.7	308.6	419.85	195.09
Female	961.3	585.3	608.8	247.9	423.56	257.88
Race [2]						
White	2,088.9	1,100.0	526.6	462.2	420.19	221.26
Non–White	411.0	193.6	470.9	83.4	430.86	202.92
Region						
Northeast	551.2	297.3	539.4	126.6	425.65	229.68
North Central	592.5	304.9	514.6	119.8	393.00	202.19
South	937.7	452.4	482.5	181.7	401.65	193.77
West	426.0	257.0	603.3	125.4	487.89	294.37

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, *Medicare: Health Insurance for the Aged and Disabled, 1976-1978; Summary–Utilization and Reimbursement by Person*, in preparation.

[1] As of July 1, 1978.

[2] Excludes persons of unknown race.

TABLE 3.18

Number of Physicians' Services and Total Charges To Medicare Enrollees, by Type of Enrollee and Census Region, 1978

Region	Number of Services (thousands)		Total Charges (millions)		Charge per Service	
	Aged	Disabled	Aged	Disabled	Aged	Disabled
United States	319,107	36,753	$7,814.4	$937.8	$24.49	$25.52
Northeast	78,709	7,970	2,519.2	224.6	32.01	28.18
North Central	81,955	9,014	1,841.5	211.6	22.47	23.47
South	97,703	12,545	2,105.2	284.5	21.55	22.68
West	60,544	7,174	1,702.9	215.4	28.13	30.03

SOURCE: Analytical Studies Branch, Office of Research, Demonstrations, and Statistics, HCFA, unpublished data.

Data on outpatient services provided to aged and disabled enrollees are presented in Tables 3.19 and 3.20. In 1978, aged enrollees received almost $800 million in reimbursements while disabled enrollees received over $480 million. The disabled accounted for about 37 percent of total reimbursements for hospital outpatient services, even though they represented fewer than 10 percent of all enrollees. Both the number of persons served per 1,000 enrollees and reimbursement per person served were higher for disabled than for aged enrollees. Reimbursement per person served was more than 4.5 times greater for the disabled ($664.10) than for the aged ($146.99). The highest amount reimbursed per person served was $1,183.60 for disabled enrollees under age 35.

Among aged enrollees, the numbers of persons served per 1,000 enrollees differed only slightly by sex and race. Differences by sex in reimbursements per person were also small. However, the amount reimbursed per person served was two-thirds greater for non-whites than for whites. Among disabled enrollees, the proportion of females who received benefits was almost 30 percent greater than the rate for males. Reimbursement per person served was also larger for females than for males, but by only 11 percent. Comparisons by race showed a striking difference in reimbursements per person served—$1,082.50 for non-whites and $564.10 for whites. Non-whites also had a higher rate of persons served per 1,000 enrollees. As a result, 30 percent of all reimbursements for hospital outpatient benefits received by disabled enrollees were paid on behalf of non-whites, who represented just over 16 percent of all disabled enrollees (Abramson, et al., May 1981; Ruther and Silverman [in press]).

Table 3.21 reports data on covered hospital outpatient charges and reimbursements for aged and disabled enrollees (excluding those with ESRD) by census region in 1979. The percents of charges reimbursed were almost identical for both types of enrollees, 66.3 percent for the aged and 67.1 percent for the disabled, even though the amount reimbursed per enrollee was about 50 percent greater for the disabled. Reimbursements per enrollee were lowest in the South and highest in the West, with about a twofold difference between the two regions. Differences in the percent of charges reimbursed varied much less by region, ranging from just over 71 percent in the West to approximately 65 percent in the South and North Central regions.

TABLE 3.19

Persons Served and Reimbursements for Outpatient Services to Aged Medicare Enrollees, by Age, Sex, and Race, 1978

Age, Sex, and Race	Number of Aged Supplementary Medical Insurance Enrollees [1] (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total	23,530.9	5,431.8	230.8	$798.4	$146.99	$ 33.93
Age						
65–69	7,835.7	1,706.7	217.8	273.4	160.18	34.89
70–74	6,283.2	1,428.5	227.3	228.6	160.00	36.38
75–79	4,427.4	1,054.8	238.2	143.0	135.61	32.31
80–84	2,902.2	706.4	243.4	87.8	124.21	30.24
85 & over	2,082.4	535.4	257.1	65.7	122.64	31.53
Sex						
Male	9,436.5	2,118.2	224.5	339.2	160.12	35.94
Female	14,094.4	3,313.6	235.1	459.2	138.59	32.58
Race [2]						
White	20,906.4	4,776.9	228.5	660.1	138.19	31.57
Non-White	1,978.0	514.8	260.3	118.2	229.66	59.78

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, *Medicare: Health Insurance for the Aged and Disabled, 1976-1978; Summary--Utilization and Reimbursement by Person*, in preparation.

[1] As of July 1, 1978.

[2] Excludes persons of unknown race.

TABLE 3.20

Persons Served and Reimbursements for Outpatient Services to Disabled Medicare Enrollees, by Age, Sex, and Race, 1978

Age, Sex, and Race	Number of Disabled Supplementary Medical Insurance Enrollees [1] (thousands)	Persons Served		Reimbursements		
		Number (thousands)	Per 1,000 Enrollees	Total Amount (millions)	Per Person Served	Per Enrollee
Total	2,543.2	723.5	284.5	$480.4	$ 664.10	$188.90
Age						
Under 35	311.9	84.4	270.5	99.8	1,183.60	319.97
35–44	303.1	85.9	283.6	82.4	958.60	271.86
45–54	579.2	169.1	292.0	122.7	725.50	211.84
55–59	550.9	157.9	286.5	82.6	523.30	149.94
60–64	798.1	226.2	283.4	92.9	410.70	116.40
Sex						
Male	1,581.8	404.4	255.6	256.4	634.10	162.09
Female	961.3	319.1	331.9	224.0	702.10	233.02
Race [2]						
White	2,088.9	576.9	276.2	325.4	564.10	155.78
Non-White	411.0	132.8	323.1	143.7	1,082.50	349.64

SOURCE: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, *Medicare: Health Insurance for the Aged and Disabled, 1976-1978; Summary--Utilization and Reimbursement by person*, in preparation.

[1] As of July 1, 1978.

[2] Excludes persons of unknown race.

TABLE 3.21

Reimbursements for Hospital Outpatient Services to Medicare Enrollees, by Type of Enrollee and Census Region, 1979

Census Region	Covered Charges (millions)		Reimbursements				Percent of Charges	
			Total Amount (millions)		Per Enrollee			
	Aged	Disabled [1]	Aged	Disabled [1]	Aged	Disabled [1]	Aged	Disabled [1]
All Areas	$1,203.0	$194.9	$797.4	$130.7	$33.09	$49.59	66.3%	67.1%
United States	1,200.2	194.4	795.6	130.5	33.32	50.27	66.3%	67.1%
Northeast	376.2	56.8	244.6	37.4	42.28	65.40	65.0%	65.9%
North Central	300.7	41.9	193.6	27.6	30.26	45.54	64.4%	65.8%
South	276.0	49.6	181.3	32.2	23.46	32.89	65.7%	64.9%
West	247.2	46.0	176.1	33.2	44.39	75.89	71.2%	72.2%

SOURCE: Raymond Goldsteen, "Medicare: Use of Hospital Outpatient Services, 1974-79," *Health Care Financing Notes*, HCFA (in press).

[1] Excludes ESRD enrollees.

C. Financing

The hospital insurance program is financed primarily through a tax on a portion of current earnings in employment covered under the Social Security Act Other sources of income for the program are proceeds from the railroad retirement system, premiums from persons who are required to pay for coverage, and interest on funds deposited with the treasury. These monies are earmarked for the hospital insurance trust fund, from which benefits and administrative expenses are paid.

The Federal supplementary medical insurance trust fund obtains funds from premiums paid by (or on behalf of) persons enrolled in the SMI program, from general revenues, and from interest on funds deposited with the treasury. At the start of Medicare, the monthly SMI premium was $3.00. On July 1, 1981, the premium became $11.00 per month. Until 1973, premiums were set to finance one-half the benefit and administrative costs of the SMI program, plus a contingency amount; general revenues financed the other half of SMI costs. The 1972 amendments altered that arrangement. Beginning in July 1973, monthly premiums could be raised only if monthly social security cash benefits were increased. Furthermore, premiums could rise no more than the percentage increase in cash benefits. General revenues finance the benefit and administrative costs not covered through premiums.

Tables 3.22 and 3.23 present data for the years 1966 through 1979 on the operations of the HI and SMI trust funds, respectively. In 1979, payroll taxes accounted for 91 percent of the HI trust fund's total income. The share of total income from payroll taxes has remained at approximately this level for the last several years. In the 1960s, the payroll tax share fluctuated between a high of 95.6 percent in 1966 and a low of 77.9 percent in 1968. Since 1967, benefit payments have accounted for well over 90 percent of all disbursements. Since the 1972 Social Security Amendments, the major source of income for the SMI trust fund has been government contributions, which made up 68 percent of total income in 1979. Enrollees' premiums contributed about 28 percent, with the remainder coming from investment interest.

D. Administration

1. Administration Under HI

The organizations responsible for paying claims under the hospital insurance program are called intermediaries. Under the HI program, groups or associations of providers, on behalf of their members, may nominate a national, State, or other public or private agency or organization to serve as their intermediary. Under an approved agreement with the Secretary of DHHS, the intermediary determines the provider's reasonable costs for items and services covered under the program, makes payment, and assists in the application of safeguards against unnecessary use of covered services. The agreement may also call for (1) furnishing consultative services to assist providers in establishing and maintaining the fiscal records needed to qualify as providers of service; (2) serving as a center for communicating with providers; and (3) making audits of provider records. Hospital insurance intermediaries also make payments for home health and outpatient hospital services covered under the SMI program.

Under the law, the reasonable costs of services are determined pursuant to regulations established by the Secretary of DHHS. Requests for Medicare payment for covered services generally are submitted by the provider of service, and the provider is reimbursed on the basis of reasonable costs of covered services, less the applicable deductible and coinsurance amounts. The beneficiary is liable for these amounts plus any amount due for non-covered services.

The provider's intermediary reviews claims for payment and pays the provider. Actual payment for individual claims is made on the basis of an interim rate established between the provider and the intermediary. Final settlement for each provider's operating year is made on the basis of a cost report submitted by the provider, and subject to an independent audit. Table 3.24 summarizes workload and cost data for Medicare HI intermediaries from 1975 through 1979. Although the number of bills processed increased 41.5 percent in that period, administrative costs increased by only 32.8 percent.

2. Administration Under SMI

Under the SMI program, the Secretary of DHHS may enter into contracts with carriers for the performance of specified administrative functions. A carrier's principal function is to compute reasonable charges and to make payment. Carriers also have the authority and responsibility to determine, in a given case, whether a claim is for a covered service and to deny claims for noncovered or excluded items or services. In addition, carriers are to apply safeguards against unnecessary use of services.

Claims for payment of SMI benefits may be submitted to the carrier either by the patient or by the service provider. If the patient submits a claim (an itemized bill) directly to the carrier, he or she receives direct payment of benefits for covered services but remains responsible for the physician's (or supplier's) bill. The patient may assign the payment for benefits to a physician or other supplier of services who is willing to accept assignment. Here the provider agrees that the reasonable charge determined by the carrier is the total charge. The physician (or supplier) submits the bill and is reimbursed 80 percent of the reasonable charge. In this situation, the patient is responsible for the remaining 20 percent of the allowed charges for covered services and for the deductible ($60 in 1981), if applicable to the current bill. Table 3.25 presents workload and cost data for Medicare SMI carriers.

E. Group Practice Prepayment Plans (GPPPs) and Health Maintenance Organizations (HMOs)

Group practice prepayment plans (GPPPs) render physicians' services and other related medical services in return for predetermined premium payments, rather than on a per visit or per service schedule.

An HMO is an organization which provides to enrolled persons, either directly or by arrangement with others, HI and SMI services on the basis of a fixed payment, without regard to the frequency or extent of services furnished to a particular enrollee.

TABLE 3.22

Operations of the Medicare Hospital Insurance Trust Fund, Calendar Years 1966-1979 (millions)

	Income								Disbursements				Trust Fund	
Year	Total Income	Payroll Taxes	Transfers From RR Retirement Account	Reimbursement for Uninsured Persons	Premiums from Voluntary Enrollees	Reimbursement for Military Wage Credits	Reimbursement for PSRO Review	Interest on Investment	Total Disbursements	Benefit Payments	Administrative Expenses		Net Change in Fund	Fund at End of Year
1966	$ 1,943	$1,858	$ 16	$ 26	—	$ 11	—	$ 32	$ 999	$ 891	$108	+	$ 944	$ 944
1967	3,559	3,152	44	301	—	11	—	51	3,430	3,353	77	+	129	1,073
1968	5,287	4,116	54	1,022	—	22	—	74	4,277	4,179	99	+	1,010	2,083
1969	5,279	4,473	64	617	—	11	—	113	4,857	4,739	118	+	422	2,505
1970	5,979	4,881	66	863	—	11	—	158	5,281	5,124	157	+	698	3,202
1971	5,732	4,921	66	503	—	48	—	193	5,900	5,751	150	-	168	3,034
1972	6,403	5,731	63	381	—	48	—	180	6,505	6,318	185	-	99	2,935
1973	10,821	9,944	99	451	$ 2	48	—	278	7,289	7,057	232	+	3,532	6,467
1974	12,024	10,844	132	471	5	48	—	523	9,372	9,099	272	+	2,652	9,119
1975	12,980	11,502	138	621 [2]	7	48	—	664	11,581	11,315	266	+	1,399	10,517
1976	13,766	12,727	143	0 [2]	9	141	—	746	13,679	13,340	339	+	88	10,605
1977	15,856	14,114	0 [1]	803 [2]	12	143 [3]	—	784	16,019	15,737	283	-	163	10,442
1978	19,213	17,324	214	688	13	141	$29	805	18,178	17,682	496	+	1,035	11,477
1979	22,825	20,768	191	734	16	141	33	942	21,073	20,623	450	+	1,751	13,228

SOURCE: The Board of Trustees, Federal Hospital Insurance Trust Fund, *1980 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* June 17, 1980, p. 27.

[1] No transfer was made in 1977 because of a change in the transfer date from August to June. The 1978 transfer is for contributions during the five-quarter period covering the transition quarter and fiscal year 1977.

[2] No transfer was made for 1976 because of the change in transfer date from December to March. The 1977 transfer was for benefits and administrative expanses during the 15-month period beginning July 1976 and ending September 1977.

[3] Includes $2 million in reimbursement from general ravenues for costs arising from the granting of noncontributory wage credits to persons of Japanese ancestry who were interned during World War II.

TABLE 3.23

Operations of the Medicare Supplementary Medical Insurance Trust Fund, Calendar Years 1966-1979 (millions)

Year	Income				Disbursements			Trust Fund	
	Total Income	Premiums from Enrollees	Government Contributions [1]	Interest on Investments	Total Disbursements	Benefit Payments	Administrative Expenses	Net Change in Fund	Fund at End of Year [2]
1966	$ 324	$ 322	$ 0	$ 2	$ 203	$ 128	$ 75	$ 122	$ 122
1967	1,597	640	933	24	1,307	1,197	110	290	412
1968	1,711	832	858	21	1,702	1,518	183	9	421
1969	1,839	914	907	18	2,061	1,865	196	– 222	199
1970	2,201	1,096	1,093	12	2,212	1,975	238	– 11	188
1971	2,639	1,302	1,313	24	2,377	2,117	260	262	450
1972	2,808	1,382	1,389	37	2,614	2,325	290	193	643
1973	3,311	1,550	1,705	57	2,844	2,526	318	468	1,111
1974	4,124	1,804	2,225	95	3,728	3,318	410	395	1,506
1975	4,673	1,918	2,648	107	4,735	4,273	462	– 62	1,444
1976	5,977	2,060	3,810	106	5,622	5,080	542	355	1,799
1977	7,805	2,247	5,385	172	6,505	6,038	467	1,301	3,099
1978	9,056	2,470	6,287	299	7,755	7,252	503	130	4,400
1979	9,768	2,719	6,645	404	9,265	8,708	557	– 502	4,902

SOURCE: The Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1980 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund,* June 17, 1980, p. 20.

[1] The payments shown as being from the general fund of the Treasury include certain interest-adjustment items.

[2] The financial status of the program depends on both the total net assets and the liabilities of the program.

TABLE 3.24

Medicare Hospital Insurance Intermediaries: Workload and Cost Data,[1] Fiscal Years 1975-1979

Fiscal Year	Number of Bills Processed (thousands)	Index	Total Administrative Cost (millions)	Index	Total Unit Cost	Index	Administrative Cost [2] (millions)	Index	Unit Cost Excluding Audit	Index	Provider Audit and Reimbursement (millions)	Index
1975	25,723.4	100.0	$151.8	100.0	$5.90	100.0	$121.5	100.0	$4.72	100.0	$36.8	100.0
1976	25,898.7	112.3	164.8	108.6	5.70	96.6	133.0	109.4	4.60	97.5	39.7	107.8
1977	32,119.0	124.1	182.3	120.1	5.68	96.3	146.8	120.8	4.57	96.8	44.1	120.0
1978	34,862.4	135.5	191.3	126.0	5.49	93.1	141.8	116.7	4.07	86.2	47.7	129.6
1979	36,410.1	141.5	201.5	132.8	5.54	93.9	147.4	121.3	4.05	85.8	52.0	141.3

SOURCE: Health Care Financing Administration, *Medicare Annual Report, Fiscal Year 1979,* p. 91.

[1] FY 1975 set at 100.

[2] For FY 1975, excludes Provider Audit cost. For FY 1976 and 1977, excludes Provider Audit, PSRO and HMO costs. For FY 1978 and 1979, excludes Provider Reimbursement, Provider Audit, PSRO and HMO costs.

TABLE 3.25

Medicare Supplementary Medical Insurance Carriers: Workload and Cost Data,[1] Fiscal Years 1975-1979

Fiscal Year	Number of Claims Processed (thousands)	Index	Administrative Cost (millions)	Index	Claims Unit Cost	Index	Payment Records Processed (thousands)	Index	Payment Records Unit Cost	Index
1975	80,613.7	100.0	$258.7	100.0	$3.21	100.0	63,837.4	100.0	$4.05	100.0
1976	92,399.5	114.6	290.2	112.2	3.14	97.8	75,266.1	117.9	3.86	95.3
1977	108,126.3	134.1	322.6	124.7	2.98	92.8	88,983.8	139.4	3.63	89.6
1978	120,439.7	149.4	344.6	133.2	2.86	89.1	100,087.3	156.8	3.43	84.7
1979	133,494.9	165.6	375.3	145.0	2.81	87.5	112,864.6	176.8	3.32	82.0

SOURCE: Health Care Financing Administration, *Medicare Annual Report, Fiscal 1979*, p. 94.
[1] FY 1975 set at 100.

Prepaid health plans that provide services to Medicare enrollees have several options for participation in Medicare. They may contract to deal directly with Medicare either under Section 1833 as group practice prepayment plans (GPPPs) or under Section 1876 as health maintenance organizations (HMOs). HMOs may contract on a cost reimbursement basis or on a risk basis. Plans that do not contract directly with Medicare are "carrier dealing" plans, billing and receiving reimbursement through the regular Medicare fee-for-service billing procedures. Medicare beneficiaries, in all cases, pay the plan (or have paid on their behalf through employment or retirement benefits) a supplementary premium to cover the Medicare deductible and coinsurance and any benefits or services provided by the plan but not covered by Medicare.

The number of contracting GPPPs and HMOs and their Medicare members are shown by size of Medicare membership in Table 3.26. As of March 1981, the 75 contracting GPPPs/HMOs had a total of 575,188 Medicare members, almost 2 percent of the total Medicare population. The four largest plans —all of them contracting as GPPPs— accounted for almost two-thirds of all Medicare members of the plans.

No data are available to show the number of Medicare beneficiaries in the carrier-dealing plans. A liberal estimate is that between 125,000 and 175,000 beneficiaries may be enrolled in them. Thus, between 2.4 and 2.6 percent of Medicare beneficiaries may be enrolled in all prepaid service plans. It should be noted, however, that some of these are union/industrial plans, which can be GPPPs but at the present time cannot become HMOs without radical changes in their enrollment and actuarial policies.

1. Group Practice Prepayment Plans (Section 1833)

Section 1833 was written into the original Medicare legislation to enable GPPPs to participate in Medicare with minimal constraints. GPPPs are paid monthly interim payments for Part B physicians' and related services based on estimated allowed costs per Medicare beneficiary and the number of Medicare member-months covered. At the end of the fiscal year, there is a post-audit adjustment based on the portion of audited costs allocated to Medicare members. Other Medicare-covered services provided by the plan are billed on a charges-related-to-cost basis, through the routine Medicare billing procedures (that is, through carriers and intermediaries).

The GPPP legislation and regulations are nonrestrictive and a wide variety of plans are currently under Section 1833 contracts, including some of the oldest and largest plans in the country. Slightly over half of the 31 GPPPs shown in the Table 3.26 are union/industrial plans that restrict membership to defined groups. The others are mostly nonprofit community plans with open membership, although most of their members may be under employment or retirement group contracts. Most of these community plans could become HMOs, and nine of them are Federally qualified HMOs but choose to remain under GPPP contracts. In comprehensiveness of service, the GPPPs vary from little more than ambulatory primary care to a full range of services, including dental care, eye care, inpatient hospital and SNF care, and home health services. Several GPPPs own or operate their own hospitals, SNFs, and HHAs. Medicare members of GPPPs may also use out-of-plan services and receive Medicare reimbursement for them. This provision allows Medicare members of GPPPs that do not provide comprehensive Medicare-covered services to receive full Medicare benefits. Reimbursement for out-of-plan services is through the routine Medicare billing process.

2. Health Maintenance Organizations (Section 1876)

The favorable cost experience of a few GPPPs led to the Federal policy of encouraging this form of delivery and payment for Medicare beneficiaries. In 1972, Section 1876 was added to the Medicare law to specify how and under what conditions HMOs may contract with Medicare. To encourage HMOs to enroll Medicare beneficiaries, the law gives them the opportunity to share in cost-saving resulting from efficient management and use of resources by entering into risk-basis contracts. If they do not choose this option, or if they cannot meet the specifications for risk contracting, they may enter into cost-basis contracts.

Two major requirements of a contracting HMO are: (1) it must be certified as Federally qualified by the Office of Health Maintenance Organizations of the Public Health Service; and (2) it must make available to its Medicare enrollees, either directly or under contractual arrangements with area providers, all of the Medicare-covered services normally available to fee-for-service Medicare beneficiaries in its service area. (Developing HMOs are given three years

TABLE 3.26

Medicare Membership in Health Maintenance Organizations (HMOs) and Group Practice Prepayment Plans (GPPPs): Number of Plans and Members by Size of Membership, March 1981

Size of Medicare Membership	All Plans		GPPPs		HMOs	
	Number of Plans	Medicare Members	Number of Plans	Medicare Members	Number of Plans	Medicare Members
Under 100	7	384	0	—	7	384
101–499	17	4,604	3	818	14	3,786
500–999	10	7,202	3	2,482	7	4,720
1,000–4,999	24	56,012	12	29,575	12	26,720
5,000–9,999	8	55,727	5	34,311	3	21,416
10,000–19,999	4	46,998	4	46,998	0	—
20,000–49,999	1	22,654	0	—	1	22,654
50,000–99,999	3	254,943	3	254,943	0	—
100,000 and over	1	126,664	1	126,664	0	—
Total	75*	575,188	31	495,791	44	79,397

* The Portland Kaiser Plan is counted twice since it has an HMO demonstration contract for 7,700 Medicare members and a GPPP contract for 13,500 Medicare members.

to meet the latter requirements.) Thus, requirements for HMOs are considerably more stringent and restrictive than those for GPPPs.

As of March 1981, 44 HMOs with a total of nearly 80,000 Medicare members were under Section 1876 contracts. Of these, 39 were under cost contracts, only one was under a normal risk contract, and 4 others were under special experimental demonstration risk contracts. (At least 4 additional HMO demonstrations are scheduled to begin during 1981.) HMOs tend to have fewer Medicare enrollees than the GPPPs; in fact, nearly half of them have fewer than 500 Medicare enrollees and only one has more than 10,000. They also tend to be newer and are more likely to be for profit. All of them are community plans; union/industrial plans cannot become HMOs because of their closed membership.

Cost-contracting HMOs function very much like GPPPs in Medicare: (1) they receive monthly interim payments during the year based on their estimated allowed costs, with a post-audit ajustment to actual allowed costs at the close of the year; and (2) their Medicare members may use and receive Medicare reimbursement for out-of-plan services. A major difference is that the HMO payments may include all Part A and Part B services, as noted above, whereas the GPPP payments are for Part B physician and related medical services only.

Section 1876 risk-contracting HMOs also receive interim payments during the year. However, in their post-audit adjustment each HMO's savings (or losses) are determined by comparing its audited allowed costs per Medicare member with the "adjusted average per capita cost" (AAPCC) for its service area. The AAPCC is computed by applying a geographic index, specific to the HMO's service area, to the average per capita costs for all Medicare beneficiaries, then further adjusting for characteristics of the HMO's Medicare membership, including age, sex, institutionalized status, and welfare status. Separate Part A and Part B AAPCCs are calculated for Medicare aged and disabled beneficiaries. If the HMO's costs are lower than its AAPCC, it retains one-half of the savings above 80 prcent of its AAPCC, for a maximum possible savings of 10 percent of the AAPCC. If the HMO's costs are higher than its AAPCC, it must absorb the loss or carry it over to be offset by future savings.

A major difference between risk HMOs and other contracting plans is that Medicare members of risk HMOs are "locked in" to the plans' services; that is, they cannot choose to use out-of-plan services and receive Medicare reimbursement for them. (Exceptions are emergency services and "urgently needed" out-of-area services.) Thus, risk HMOs must make all Medicare-covered services available to Medicare members.

3. All Other Plans

The majority of prepaid health service plans do not contract with Medicare under either Section 1833 or Section 1876. The Office of Health Maintenance Organizations (OHMO), which conducts an annual survey of HMOs, lists a total of 236 HMOs as of June 1980 (National HMO Census, 1980). Of these, 58 have either GPPP or HMO contracts with Medicare. The majority of the noncontracting HMOs reported very few Medicare members. Union/industrial plans are not listed by OHMO since they cannot become HMOs. However, 16 plans currently under GPPP contracts are union/industrial plans, and the delivery system, and payment methods in most of the noncontracting union/industrial plans necessitate that they be considered prepaid health service plans. Although the number of such plans is unknown, it is known that some plans are quite large and serve a substantial number of Medicare beneficiaries. The noncontracting plans that accept Medicare beneficiaries as members obtain reimbursement for the Medicare-covered portion of their costs through the routine Medicare billing and payment procedures.

F. The Medicare Statistical System

The Medicare Statistical System provides data for the measurement and evaluation of program operations and effectiveness. The system is based on four major computer files: the health insurance master file, the provider of service file, the hospital insurance (HI) claims file, and the supplemental medical insurance (SMI) payment record file.

The health insurance master file maintains a record for each aged and disabled person enrolled for Medicare coverage, indicating the type of entitlement and information about the enrollee's deductible status, benefit period status, and benefits used. This master file provides population data for each part of the program, serving as a base for the computation of a variety of use (specifically, by age, sex, race, and residence).

The provider of service file records information on participating providers. Hospitals, home health agencies, skilled nursing facilities, independent clinical laboratories, and suppliers of portable X-ray or outpatient physical therapy services must apply for participation in the Medicare program. The provider of service files consist of data from the application forms. For hospitals, it includes data on the number of beds, type of ownership, and a variety of institutional characteristics. Data on providers of service are updated regularly.

The hospital insurance claims file maintains information on beneficiaries' entitlement under the program and the extent to which beneficiaries have used covered benefits. When a Medicare enrollee has made use of a medical facility for which HI coverage applies (for example, a hospital or skilled nursing facility), admission and billing forms are forwarded to HCFA's central record section. Each admission and billing form contains both the beneficiary's claim number and the provider's identification number. This information is used to administer the "benefit period" provision. Recorded information includes stays in certain nonparticipating institutions that met the definition of a hospital or skilled nursing facility under the law, and days of care not covered or reimbursable under the program. As part of the data collection process, information on diagnoses and surgical procedures is coded for a 20-percent sample of enrollees who enter short-stay hospitals.

The SMI payment record file contains information on reimbursements under the SMI program. The file allows carriers to determine whether beneficiaries have met the annual $60 deductible, and provides accurate and complete information on the amounts paid by the carriers for physicians' services and for other services and supplies under this part of the program. A bill summary file is also derived from a 5-percent sample of the SMI payment record file.

The Medicare statistical system enables HCFA to prepare a wide variety of statistical and analytical reports and studies on the use and reimbursement of health care services financed by Medicare. These data are used to provide cross-sectional and longitudinal information about the use of benefits by program enrollees. Statistical reports are produced on enrollments, the characteristics of participating providers, reimbursements, benefits paid per person served, and service utilization. HCFA is also implementing a new Medicare data base, the Continuous Medical History Sample (CMHS), beginning with 1974 data. This system will provide longitudinal data on the use of services by Medicare beneficiaries, using a 5-percent sample of Medicare beneficiaries. The system provides for linkage of records of every Medicare service used by each beneficiary in the sample. This linkage is the key to the flexibility of the Medicare Statistical System, in that it allows for the development of detailed analysis for any specified group of Medicare beneficiaries or providers.

IV. The Medicaid Program: Description And Data

This chapter presents detailed information on the Medicaid program, including eligibility criteria, recipient characteristics, benefit coverage, service use, expenditures, financing, and administration.[14] Explanations of program requirements are based on Title 42 of the Code of Federal Regulations, Parts 430-450. Section A, on eligibility, discusses the requirements and options States face in defining the categorically and medically needy. Classes of eligibles covered and the income standards for eligibility are presented for each State. In Section B, data are presented on the distribution of recipients among and within States, by eligibility status, age, and sex.

States' Medicaid benefits are described in Section C. Each State's optional services, benefit limitations and cost-sharing requirements are identified. Changes in State plans between January and December 1980 are also reported. Section D presents data on service use under Medicaid. For each State, data include the distribution of recipients by service; the absolute number of recipients, and total volume of service by type of service; the number of EPSDT screenings and the percent of screenings that revealed a condition; and the number and types of sterilization procedures.

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[14] The numbers presented in the data tables may differ from those in previous publications, including those found in former editions of the data book. These differences are mainly due to the receipt by HCFA of late reports and adjustments.

Section E reports on Medicaid expenditures for each State. Data show the distribution of State expenditures by eligibility category, age and sex of recipients, and service. Comparisons of States' average expenditures per recipient and ratios of Medicaid recipients to persons at or below the poverty level are also presented. Section F describes Medicaid financing, with information on matching rates for Federal financial participation, the distribution of expenditures among Federal, State, and local governments, and recipients and expenditures covered under State buy-ins to Medicare.

Finally, Medicaid administration is described. Topics include provider reimbursement methods, expenditures for administrative training and nursing home surveyors, numbers of certified providers, administrative responsibility for eligibility determination, adoption of management and information systems, and fraud and abuse.

A. Eligibility

Medicaid is a major component of the current welfare system and its eligibility provisions are among the most complex of all assistance programs. At a minimum, States must cover all persons who receive cash payments from either the Aid to Families with Dependent Children (AFDC) program or, in most cases, the supplemental security income (SSI) program. States have the option of extending Medicaid coverage to the medically needy and to specified groups of people known as the optionally categorically needy. The medically needy are defined as categorically related individuals who are ineligible for cash assistance on the basis of income and financial resources but whose income and resources are considered insufficient to meet their medical needs. This section describes the standards States use to determine who is eligible for Medicaid as either categorically or medically needy.

1. The Categorically Needy

As shown in Figure 4.1, the categorically needy include AFDC and SSI cash assistance recipients and may also include optional groups related to each cash assistance category. The AFDC and SSI categories are discussed in turn.

a) AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

The State Medicaid programs must include all persons receiving aid under the State's AFDC plan as well as individuals under age 21 who are eligible if they meet age or school attendance requirements, and families terminated from cash assistance because of increased earnings or hours of employment. At the State's option, the AFDC State Plan may include families with unemployed parents, families with unborn children, and children age 18-21 regularly attending school. If the State extends AFDC coverage to these groups, it must extend Medicaid coverage as well.

At the discretion of a State, a Medicaid program can extend benefits to specified AFDC-related groups. These AFDC optionally categorically needy include the following:

(1) Individuals who are eligible for but are not receiving cash assistance;
(2) certain institutionalized individuals, including those eligible for cash assistance but not receiving it because they are institutionalized;
(3) certain relatives who are caring for children under age 21 who would be eligible for AFDC payments except for AFDC age or school attendance requirements;
(4) all persons under age 21 who meet the AFDC income and resource limits but do not meet the definition of a dependent child under the AFDC program, for example, emancipated children. States may limit coverage to reasonable groups such as children in foster homes, subsidized adoptions, psychiatric institutions, or intermediate care facilities;
(5) individuals who would be eligible for AFDC payments if they did not receive child care services through the agency but had to pay child care costs out of their earnings;
(6) persons who would be eligible for AFDC payments if the State AFDC program were as broad as the Social Security Act allows.

Table 4.1 indicates the categories of AFDC-related persons covered by each State's Medicaid program in 1980.

States determine the income standards for cash assistance and Medicaid eligibility. Table 4.2 presents the annual need and payment standards for AFDC families by State. The AFDC payment standards determine eligibility for Medicaid. Data are shown for two family sizes (2 and 4 persons). Data for other family sizes are available from State public assistance plans. There is considerable variation in the payment standards across the Medicaid jurisdictions from a high of $6,552 in Hawaii to a low of $1,512 in Puerto Rico for four-person families.

The need standard is the amount of money a State determines essential to meet a minimal standard of living in that State for a specified family size. In general, the standard provides for basic consumption items such as food, clothing, shelter, fuel and utilities, personal care items, household items, and in certain cases special or recurrent needs. Some States vary the need standard to reflect differences in actual costs within the State, some States vary the need standard by season, and one State varies the amount of money on the basis of the age of the child.

The payment standard is established by each State and determines the extent to which the State cash assistance program will meet the need for a minimal standard of living. Approximately one-half of the States set a payment standard that is lower than the need standard. It should be noted, however, that a State meeting less than full need but having a high need standard may provide a substantially higher level of assistance than a State meeting full need under a low need standard. In addition, States place a maximum on the payments allowed. For the majority of States that maximum is equal to the payment standard; however, in four States the maximum is below the need standard and the payment standard. Those States where the maximum is below the need standard and the payment standard are footnoted in Table 4.2.

FIGURE 4.1

Eligibility Coverage Of The Categorically Needy

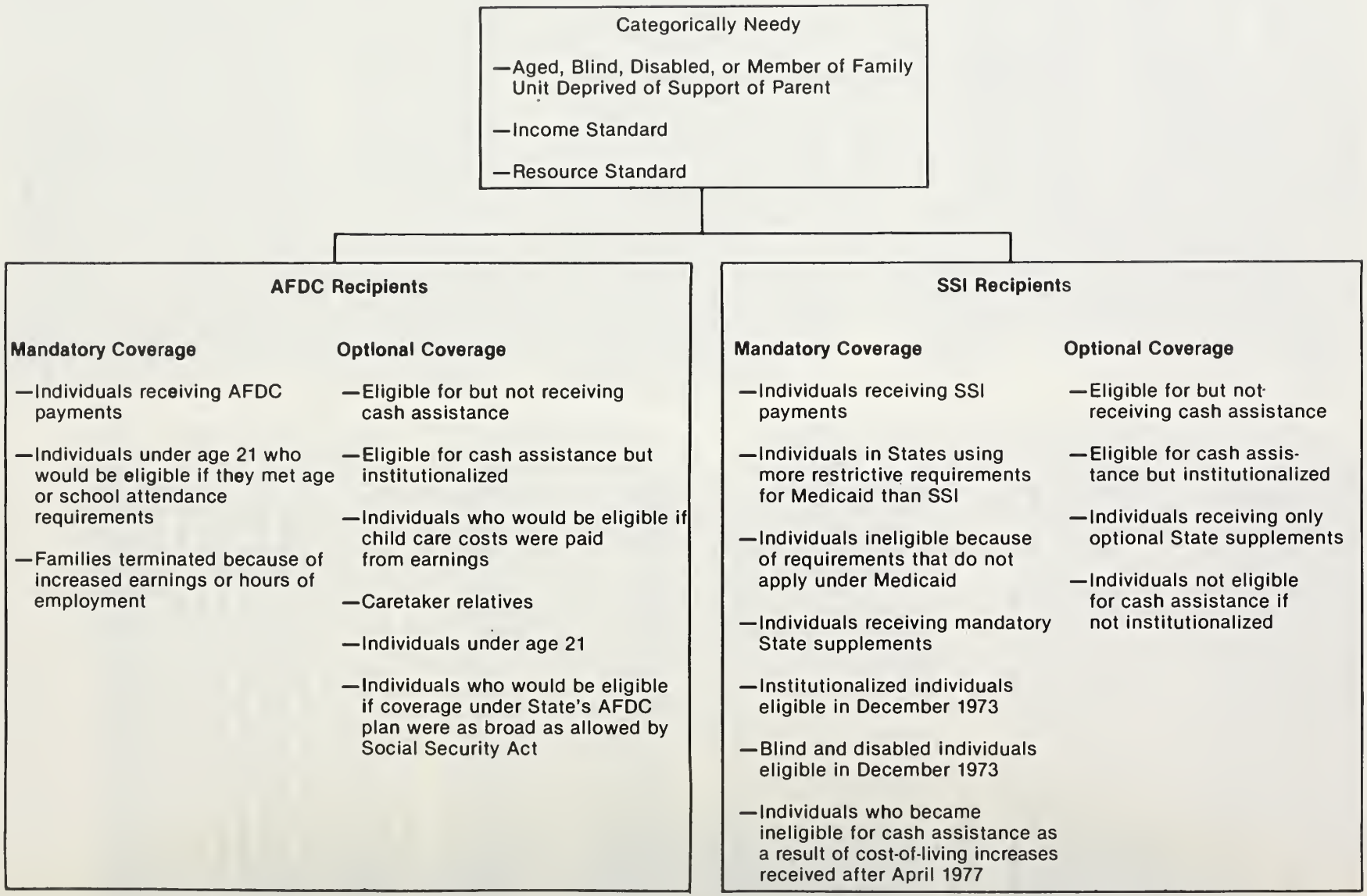


TABLE 4.1

Medicaid Coverage Under AFDC by Jurisdiction
December 1980

	AFDC State Plan Includes			Optional Categorically Needy					
Medicaid Jurisdiction	Families with Unemployed Parents	Unborn Children	Children Age 18–21 Regularly Attending School	Caretaker Relatives	All Financially Eligible Individuals Under Age 21	Individuals Eligible But Not Receiving Aid	Individuals Eligible But In Institutions	Individuals Who Would Be Eligible If AFDC Is Broad As Social Security Act Allows	Individuals Who Would Be Eligible If Child Care Cost Paid From Earnings
Alabama		x	x		x		x		
Alaska			x			x	x		
Arkansas			x		x		x		x
California	x	x	x	x	x	x	x		
Colorado	x	x	x	x		x	x		
Connecticut	x	x	x	x	x	x			
Delaware	x	x	x	x			x	x	
District of Columbia	x	x	x	x	x	x	x	x	x
Florida		x					x		
Georgia			x		x		x		
Guam	x	x	x						
Hawaii	x	x	x	x	x		x	x	
Idaho			x		x	x	x		
Illinois	x		x				x	x	
Indiana									
Iowa	x		x				x	x	
Kansas	x	x	x	x					
Kentucky			x	x	x	x		x	
Louisiana		x	x	x	x		x		
Maine				x	x	x	x	x	
Maryland	x	x	x	x	x	x	x	x	
Massachusetts	x	x	x	x	x	x	x		
Michigan	x	x	x	x	x				
Minnesota	x	x	x	x	x		x		x
Mississippi				x			x	x	
Missouri	x	x	x				x	x	x
Montana	x	x	x		x	x	x		x
Nebraska	x	x	x				x		
Nevada		x	x		x		x	x	
New Hampshire			x	x	x	x	x		
New Jersey	x	x	x	x	x	x	x	x	
New Mexico		x	x	x					x
New York	x	x	x	x		x	x	x	x
North Carolina			x	x					
North Dakota		x	x	x	x	x	x		x
Northern Marianas	x	x	x	x	x	x			x

(continued)

TABLE 4.1
Medicaid Coverage Under AFDC by Jurisdiction
December 1980
(continued)

	AFDC State Plan Includes			Optional Categorically Needy					
Medicaid Jurisdiction	Families with Unemployed Parents	Unborn Children	Children Age 18–21 Regularly Attending School	Caretaker Relatives	All Financially Eligible Individuals Under Age 21	Individuals Eligible But Not Receiving Aid	Individuals Eligible But In Institutions	Individuals Who Would Be Eligible If AFDC Is Broad As Social Security Act Allows	Individuals Who Would Be Eligible If Child Care Cost Paid From Earnings
Ohio	x	x	x				x	x	x
Oklahoma			x	x	x	x	x		x
Oregon			x	x	x	x	x	x	
Pennsylvania	x	x		x	x	x	x	x	x
Puerto Rico				x	x	x	x	x	
Rhode Island	x	x	x	x	x	x	x		
South Carolina		x	x	x	x		x		
South Dakota		x					x		
Tennessee		x	x		x				
Texas			x				x		
Utah	x	x	x	x	x	x	x		
Vermont	x	x	x	x	x	x	x		
Virgin Islands			x	x	x	x	x	x	
Virginia			x	x		x	x		x
Washington	x	x	x		x	x	x		x
West Virginia	x	x	x			x			
Wisconsin	x	x		x	x	x	x		x
Wyoming		x	x				x		

SOURCE: State Plans Branch, Bureau of Program Operations, HCFA.

TABLE 4.2

Annual AFDC Need and Payment Standards and Annual Net Income Levels for Medically Needy for Determining Medicaid Eligibility by Jurisdiction

Medicaid Jurisdiction	Annual Need and Payment Standards (July 1979)				Ranking by Payment Standard	Annual Net Income Protected for Maintenance for the Medically Needy[2] (December 1980)			
	2 Person Family		4 Person Family						
	Need	Payment[1]	Need	Payment[1]	(4 Person Family)	1 Person Family	2 Person Family	4 Person Family	6 Person Family
Alabama	$1728	$1068	$2830	$1776	52				
Alaska	4200	4200	5400	5400	12				
Arkansas	2316	1596	3276	2256	49	$1700	$2200	$3100	$3900
California	4104	3972	6132	5844	6	3492	5304	7800	9996
Colorado:									
Nov–Mar	2772	2772	4164	4164	27				
Apr–Oct	2568	2568	3924	3924	33				
Connecticut:	4296	4296	6204	6204	5				
Region A[4]						3300	4500	6000	7500
Region B[4]						3100	4200	5100	6600
Region C[4]						2900	4100	5000	6500
Delaware	2172	2172	3444	3444	39				
District of Columbia	3732	2700	5772	4188	25	3097	4738	4864	5795
Florida	1800	1800	2760	2760	45				
Georgia	1932	1452	2724	2040	51				
Guam	2412	2412	3672	3672	36	1500	2500	3000	3400
Hawaii	4680	4680	6552	6552	1	3600	4800	6600	8400
Idaho	3576	3120	5052	4404	23				
Illinois	2724	2724	3996	3996	30	2160	2724	3996	5388
Indiana[5]	2964	2664	4356	3924	33				
Iowa	3504	3504	5028	5028	13				
Kansas	3420	3420	4500	4500	20	3360	3960	4920	5880
Kentucky	1620	1620	2820	2820	44	2200	2600	3800	5000
Louisiana:	3468	1320	5928	2244	50				
Urban						1800	2004	3504	4596
Rural						1704	1800	3204	4404
Maine	2460	2340	4188	3984	31	2880	3400	5700	8000
Maryland	2436	2280	3768	3528	38	2904	3408	4104	5090
Massachusetts[6]	3348	3348	4752	4752	14	3600	4500	5280	6480
Michigan:[7]	3936	3936	5640	5640	9				
Zone I[8]						3270	4728	5992	8044
Zone II[8]						3230	4728	5964	8016
Minnesota	3852	3852	5448	5448	11	3288	3600	5088	6420
Mississippi[5]	2256	2256	3024	3024	41				
Missouri	3000	2220	4380	3240	40				
Montana	2316	2316	3972	3972	32	2496	3096/3696[9]	5304	6996
Nebraska	3000	3000	4440	4440	22	3100	4000	5600	7200
Nevada	2748	2388	4092	3564	37				
New Hampshire	3504	3504	4704	4704	15	2988	3468	4572	5712
New Jersey	3060	3060	4632	4632	19				
New Mexico	1956	1956	2904	2904	43				
New York[7]	3996	3996	5712	5712	8	3700	5300	5500	6500
North Carolina	2004	2004	2520	2520	47	2100	2700	3400	4000
North Dakota	2964	2964	4668	4668	16	2880	4320	6360	7980
Northern Marianas						1800	2400	3420	4200

(continued)

TABLE 4.2

Annual AFDC Need and Payment Standards and Annual Net Income Levels For Medically Needy for Determining Medicaid Eligibility by Jurisdiction (continued)

Medicaid Jurisdiction	Annual Need and Payment Standards (July 1979)				Ranking by Payment Standard	Annual Net Income Protected for Maintenance for the Medically Needy[2] (December 1980)			
	2 Person Family		4 Person Family						
	Need	Payment [1]	Need	Payment [1]	(4 Person Family)	1 Person Family	2 Person Family	4 Person Family	6 Person Family
Ohio	3408	2592	5172	3924	33				
Oklahoma	2616	2616	4188	4188	25	2900	3500	5600	7500
Oregon	5136	4116	8532	6300	2				
Pennsylvania	3120	3120	4476	4476	21	2900	4350	4750	5900
Puerto Rico	936	936	1512	1512	55	2500	3200	4400	5600
Rhode Island:						4400	4900	6900	8700
Dec-Mar	4416	4416	6216	6216	4				
Apr-Nov	3312	3312	4668	4668	16				
South Carolina [5]	1728	1728	2748	2748	46				
South Dakota	3360	3360	4332	4332	24				
Tennessee	1704	1092	2604	1668	52	1404	1600	2400	3300
Texas	1380	1032	2244	1680	54				
Utah	4044	3036	6228	4668	16	2748	3792	5832	8364
Vermont	5784	4620	7872	6288	3				
Chittendon Co.						3456	4608	6036	7404
All other areas						3210	4344	5796	7176
Virgin Islands	1848	1440	3156	2460	48	2200	2750	3630	4510
Virginia:	3204	2880	4464	4020	29				
Group I [10]						2300	2700	3500	4500
Group II [10]						2500	3100	3800	4900
Group III [10]						3100	3800	4400	5700
Washington	4068	4068	5796	5796	7	3384	4824	6432	8304
West Virginia	2628	1968	3984	2988	42	2004	2196	3300	4296
Wisconsin	4452	3912	6240	5496	10	3611	5544	7000	8700
Wyoming	3360	3360	4080	4080	28				

SOURCES: Annual AFDC Need and Payment Standards--Office of Research and Statistics, Social Security Administration, DHHS; Annual Net Income Protected for Maintenance for the Medically Needy--State Plans Branch, Bureau of Program Operations, HCFA.

[1] Payment standards and maximum payments are the same with the exception of the states that have been footnoted.

[2] The following 20 states do not include the "medically needy" in the scope of their program: Alabama, Alaska, Colorado, Deleware, Floride, Georgia, Idaho, Indiana, Iowa, Mississippi, Missouri, Nevada, New Jersey, New Mexico, Ohio, Oregon, South Caroline, South Dakota, Texas, and Wyoming.

[3] Net income level protected for maintenance is $221 when all other family members are Public Assistence recipients.

[4] Annual gross income minus employment expense or other appropriate disregard.

[5] The highest annual amount of maximum payment is lower than the payment standard.

[6] Includes quarterly grant monies.

[7] Michigan and New York have differentieted shelter cost areas; reported are Wayne County, Michigan and New York shelter maximums.

[8] Zones are based on geographical location with Counties assigned to areas within zones; Zone I consists of 6 Areas, Zone II consists of 5 Areas. The numbers shown represent the mean protected income for each zone.

[9] $3,096 is for 2 person households with 1 adult and 1 child; $3,696 is for 2 person households with 2 adults.

[10] Groups are composed of specific counties and cities based on cost of shelter differentiels. In general, Group I is the south and western part of the state; Group II is the central part, and Group III is Northern Virginia.

b) SUPPLEMENTARY SECURITY INCOME (SSI)

Prior to 1974, States had the same authority to set cash assistance and Medicaid eligibility standards for the aged, blind, and disabled, as they had for the AFDC population. Since 1974, however, the Federal SSI program has established minimum income standards for cash assistance to the aged, blind, and disabled. When the SSI program began, States were permitted to choose one of three ways to determine Medicaid eligibility for these persons. The Medicaid program could cover:

(1) All persons receiving an SSI benefit, including their eligible spouses;
(2) all persons receiving an SSI benefit or State supplementary payment, including their eligible spouses; or
(3) all persons who met the eligibility criteria for medical assistance which were in effect on January 1, 1972, or some less restrictive criteria. These criteria must be more restrictive than the criteria for SSI benefits or State supplements and they must be applied to the individual's income after subtracting his or her SSI benefit, State supplementary payment, and incurred medical expenses. States taking this option are known as "209(b)" States and this deduction is referred to as the "209(b) spend-down."

States were also required to provide Medicaid coverage to the following groups which were eligible for Medicaid in December 1973:

(1) blind and disabled individuals;
(2) essential spouses;
(3) institutionalized individuals; and
(4) individuals receiving a mandatory State supplementary payment.

These requirements were established to prevent the loss of eligibility for cash assistance recipients in transition to SSI. Individuals could have lost eligibility if States narrowed their definitions of disability or visual impairment. To prevent this, on December 1973, recipients of Aid to the Blind (AB) and Aid to the Permanently and Totally Disabled (APTD) were deemed to meet the SSI criteria for disability or blindness in States with more liberal categorical definitions. Individuals also could have lost their eligibility if SSI used lower income and resource levels than their State had previously employed. Therefore, States with more liberal financial standards were required to pay the difference between the lower SSI benefit and the individual's previous cash benefit and to extend Medicaid benefits to such individuals. This requirement is called mandatory supplementation. Although the mandatory supplement comes out of State revenues, it may at State option be administered by the Federal government.

To protect individuals in States choosing not to extend Medicaid coverage to all SSI recipients, the law required that all 209(b) States adopt a "spend-down" for Medicaid; that is, determine eligibility based on income less SSI payment, any optional State supplement payment, and any incurred medical expenses. This 209(b) or categorically needy spend-down applies only for those categories for which more restrictive eligibility criteria are imposed, should the State elect not to impose more restrictive criteria on all categories. Although the provisions are directed primarily at States choosing to impose more restrictive income standards, these provisions are equally applicable if a State elects to impose any criteria more restrictive than those used under SSI. As a result of these provisions, even 209(b) States without a medically needy program must permit all individuals to spend down; all other States need not extend this coverage.

The option to cover certain additional sets of persons as categorically needy was also offered to the States. These groups could be covered no matter which of the three basic coverage options was chosen by the State; they include persons eligible for but not receiving cash assistance, certain institutionalized persons, and individuals receiving only optional State supplements. States electing to make optional supplementary payments are permitted to limit these payments to reasonable classifications of categorically related individuals. Table 4.3 indicates the categories of SSI eligibles to which each State offered Medicaid eligibility in 1980.

2. The Medically Needy

The medically needy program is one of the most important overall options for coverage that can be exercised under the Medicaid program. The general intent of the medically needy option is to accomodate individuals who meet all criteria for categorically needy assistance with the exception of income and who have incurred relatively large medical bills (see Figure 4.2). As of 1969, the medically needy income standards were limited to 133-1/3 percent of the maximum assistance payments for similarly sized families under AFDC in a given State. That is, families whose monthly incomes are between the AFDC payment standard and 133-1/3 percent of that standard are eligible for assistance as medically needy. Table 4.2 indicates the thirty-one jurisdictions which have medically needy programs and lists the annual income levels for the medically needy by number of family members by State.

Through the spend-down provision, persons or families can also become eligible for medical assistance under the medically needy program if they have income above the 133-1/3 percent level but have high medical expenses which reduce income below the medically needy maximum. The expanded coverage permitted under a medically needy program affects all categorically related groups, because States with medically needy programs are required to cover as medically needy all categorically related groups otherwise covered under their Medicaid programs.

There are also groups of individuals which States may cover entirely at their own expense. These groups are referred to as non-categorically medically needy or "State-only" eligibles, and include individuals such as those who are receiving or are eligible for general assistance under a Statewide program; persons between the ages of 21 and 65 who are judged to have income and resources sufficient for daily needs but not for medical expenses, and who are not eligible for Medicaid under the adult or AFDC categories; and persons with income above the Federally established maximum for the medically needy. Persons covered fully at State expense need not meet any of the requirements for categorical eligibility. Thus, for example, a young, single male above the age of 21 and living alone could receive Medicaid benefits as a State-only eligible.

TABLE 4.3

Medicaid Coverage Under SSI by Jurisdiction
December 1980

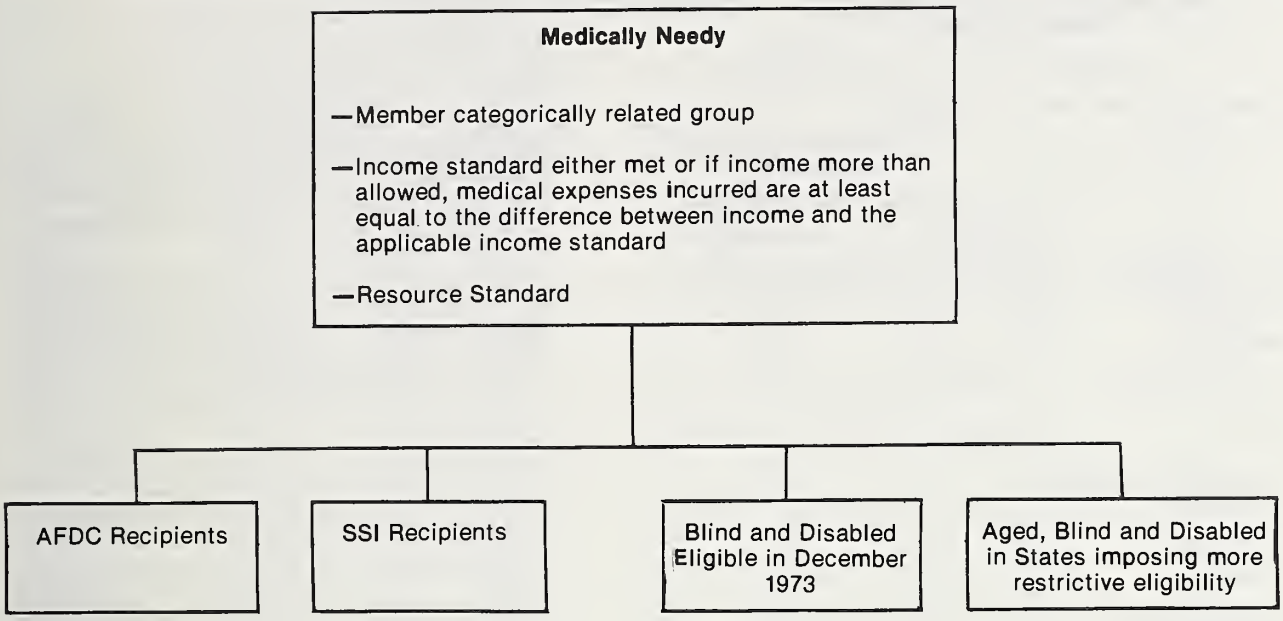
Medicaid Jurisdiction	All SSI Recipients	More Restricted Standard	Optional Categorically Needy				
			State Supplement Recipients			Individuals Eligible But Not Receiving Aid	Individuals Eligible But In Institutions
			Aged	Blind	Disabled		
Alabama	x		x	x	x		x
Alaska	x		x	x	x	x	x
Arkansas	x						x
California	x		x	x	x	x	x
Colorado	x		x			x	x
Connecticut		x	x	x	x	x	
Delaware	x		x	x	x	x	x
District of Columbia	x					x	x
Florida	x						x
Georgia	x						x
Guam[1]							
Hawaii		x	x	x	x		x
Idaho	x		x	x	x	x	x
Illinois		x	x	x	x		x
Indiana		x	x	x	x		
Iowa	x		x	x	x		x
Kansas	x						
Kentucky	x		x	x	x		
Louisiana	x						x
Maine	x		x	x	x	x	x
Maryland	x		x	x	x	x	x
Massachusetts	x		x	x	x	x	x
Michigan	x		x	x	x		
Minnesota		x	x	x	x		x
Mississippi		x					x
Missouri		x	x	x	x		x
Montana	x		x	x	x	x	x
Nebraska		x	x	x	x		x
Nevada	x		x	x			x
New Hampshire		x	x	x	x	x	x
New Jersey	x		x	x	x	x	x
New Mexico	x						x
New York		x	x	x	x	x	x
North Carolina		x	x	x	x		
North Dakota		x				x	x
Northern Marianas[1]	x					x	
Ohio		x					x
Oklahoma		x	x	x	x	x	x
Oregon	x		x	x	x	x	x
Pennsylvania	x		x	x	x	x	x
Puerto Rico[1]	x					x	x
Rhode Island	x		x	x	x	x	x
South Carolina	x		x	x	x		x
South Dakota	x		x	x	x		x
Tennessee	x						
Texas	x						x
Utah		x				x	x
Vermont	x		x	x	x	x	x
Virgin Islands[1]						x	x
Virginia		x	x	x	x	x	x
Washington	x		x	x	x	x	x
West Virginia	x					x	
Wisconsin	x		x	x	x	x	x
Wyoming	x						x

SOURCE: State Plans Branch, Bureau of Program Operations, HCFA.

[1] Eligibility determination for the territories is based on separate regulations which are found in 42 CFR 436. The Medicaid agency may not require a separate application for Medicaid from an individual if the individual receives cash assistance under a State plan for OAA, AFDC, AB, APTD, or AABD.

FIGURE 4.2

Eligibility Coverage Of The Medically Needy



B. Recipients [15]

This section presents data on Medicaid recipients, by maintenance assistance status, eligibility category, and demographic characteristics. Table 4.4 shows the distribution of Medicaid recipients by basis of eligibility and maintenance assistance status. Individuals eligible for Medicaid are classified into two main groups according to their maintenance assistance status. "Cash assistance recipients" are those who receive cash assistance for their basic necessities under public assistance programs. "Medical assistance only" individuals are those who do not receive cash assistance. This group includes both the "medically needy" and "categorically eligible" persons not receiving cash assistance. Within each of these two main groups, eligible individuals are classified by basis of eligibility. Eligibility groups include age 65 and over, blind, permanently and totally disabled, children in families with dependent children under 21, and adults in families with dependent children under 21. As described above, some States extend Medicaid coverage to other needy persons who do not fall into any of the above categories. Such persons are classified as "other Title XIX recipients." Individuals who are not eligible for matching Federal financial participation but are covered solely out of State funds are not included in Table 4.4.

For FY 1979 there were approximately 21.5 million Medicaid recipients. Seventy-four percent were cash assistance recipients and 25.9 percent were medical assistance recipients only. The two largest recipient groups were AFDC-related, with 9.1 million recipients being dependent children under 21, and 4.6 million being adults in families with dependent children. The aged were the third largest recipient group, with 3.4 million recipients. Of this group 38.3 percent were "medical assistance only" recipients, indicating that nearly two-fifths of the aged Medicaid recipients were not receiving cash assistance.

Table 4.5 reports the number of Medicaid recipients by jurisdiction for FY 1979. Jurisdictions are ranked by their percentage of all recipients, and the cumulative percent of national recipients is presented. The table also shows the distribution of each State's recipients by category of eligibility. About 64 percent of all recipients were eligible under the AFDC category and about 16 percent were eligible as 65 or over. The permanently and totally disabled made up 12.4 percent of all recipients; 8.1 percent were "Other Medicaid" recipients and 0.4 percent were blind. California had the largest number of recipients with 3.4 million or 15.7 percent of the total. Six jurisdictions (combined)—California, New York, Puerto Rico, Pennsylvania, Massachusetts, and Illinois—accounted for almost 50 percent of all Medicaid recipients, and 17 jurisdictions serve over 75 percent of all Medicaid recipients.

Table 4.6 shows the distribution of recipients by age and sex for all jurisdictions for FY 1979. Of the 21.5 million recipients, 47.5 percent were below 21 years of age and 17.5 percent were above 64 years. The percentage of female recipients was almost double that of male recipients, 64.7 percent compared to 34.4 percent.

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[15] Adjustments have been made in recipient counts for New York and Pennsylvania. See National Annual Medicaid Statistics, 1979, "Technical Appendix" for a detailed discussion of the data problems and compensating adjustments.

TABLE 4.4

Number of Medicaid Recipients by Basis of Eligibility and Maintenance Assistance Status Fiscal Year 1979

Basis of Eligibility	Number of Recipients (thousands)	Percentage Distribution by Maintenance Assistance Status	
		Cash Assistance	Medical Assistance Only
All Eligibility Categories	21,540.0	74.1%	25.9%
Age 65 and Over	3,354.1	61.7%	38.3%
Blind	80.2	83.2%	16.8%
Permanently and Totally Disabled	2,661.2	76.2%	23.8%
Dependent Children Under 21	9,143.0	86.7%	13.3%
Adults in Families with Dependent Children	4,553.4	85.1%	14.9%
Other Title XX Recipients	1,748.2	Not Applic.	100.0%

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

C. Service Coverage and Limitations

Federal regulations pertaining to Title XIX mandate that certain basic services be offered to all categorically needy persons. States receive Federal Financial Participation (FFP) for these basic services as well as specified services covered at States' option. States have the option of limiting the scope of coverage for both required and optional services, but must make all covered services available throughout their State.[16] All States participating in Medicaid must cover the following basic services:

1. Inpatient hospital services, other than services in an institution for tuberculosis or mental disease. This category includes items and services ordinarily furnished by the hospital for the care and treatment of inpatients, provided under the direction of a physician or dentist. The hospital must be licensed or formally approved as a hospital by an officially designated State standardsetting authority and either qualified to participate under Medicare or determined to currently meet the requirements for such participation. It must also have in effect a hospital utilization review plan applicable to all patients who receive medical assistance under the Medicaid program.
2. Outpatient hospital services, including preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a hospital outpatient. The hospital must meet the same requirements as for inpatient services: the hospital must be licensed or formally approved as a hospital and must be qualified to participate under Medicare, or must meet the requirements for such participation.
3. Rural health clinic services in certified clinics must be provided and furnished by a physician or by a physician assistant, nurse practitioner, nurse midwife or other specialized nurse practitioner (in States where those professionals are not prohibited by State law from furnishing primary health care).
4. Other laboratory and X-ray services, including professional and technical laboratory and radiological services ordered by a physician or other licensed practitioner, within the scope of his practice as defined by State law and provided to a patient by, or under the direction of, a physician or other licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. These services must be provided to a patient by a laboratory that is qualified to participate under Medicare, or is determined to meet the requirements for such participation.
5. Skilled nursing facility (SNF) services for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases. These services must be ordered by and under the direction of a physician. The facility must be qualified for participation in Medicaid. For all eligible individuals who are entitled to skilled nursing facility services under the State plan, home health services must also be provided.
6. Physicians' services, whether provided in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere. Physicians' services are defined to included the services provided within the scope of practice of the profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.
7. Early and periodic screening, diagnosis, and treatment (EPSDT) for recipients under age 2l. This includes screening and diagnostic services to determine physical or mental defects as well as health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.
8. Family planning services and supplies for individuals of child bearing age who are eligible for Medicaid and desire such services and supplies.

[16] This "Statewideness" rule may be waived for a limited period of time for the purpose of conducting special demonstration studies.

TABLE 4.5
Number of Medicaid Recipients by Jurisdiction, by Rank of Jurisdiction, and by Basis of Eligibility
Fiscal Year 1979

Medicaid Jurisdiction	Number of Recipients (thousands)	Percent of Total	Cumulative Percent of National Total[1]	Percentage Distribution by Basis of Eligibility				
				Age 65 And Over	Blindness	Permanent and Total Disability	AFDC	Other Title XX Recipients
All Jurisdictions	21,540.0	100.0%	100.0%	15.6%	0.4%	12.4%	63.6%	8.1%
California	3,373.7	15.7	15.7	15.6	0.5	14.8	62.8	6.3
New York	2,364.0	11.0	26.7	13.7	0.2	10.5	65.5	10.1
Puerto Rico	1,424.2	6.6	33.3	—	(Z)	2.7	50.5	46.8
Pennsylvania	1,390.3	6.5	39.8	7.8	0.3	10.1	61.4	20.4
Massachusetts	1,046.3	4.9	44.7	20.0	0.7	10.2	59.6	9.5
Illinois	1,015.8	4.7	49.4	8.1	0.1	13.0	77.6	1.1
Michigan	897.7	4.2	53.6	10.1	0.2	11.8	76.9	1.0
Ohio	725.8	3.4	57.0	10.9	0.3	12.1	76.7	—
Texas	681.5	3.2	60.2	35.6	0.6	14.9	48.9	—
New Jersey	662.7	3.1	63.3	9.2	0.2	9.0	79.1	2.6
Florida	435.9	2.0	65.3	26.1	0.5	19.5	53.8	—
Wisconsin	420.0	1.9	67.2	18.2	0.2	11.8	68.6	1.1
Kentucky	406.8	1.9	69.1	18.0	0.6	15.7	65.8	—
Georgia	401.3	1.9	71.0	25.1	0.6	20.9	53.4	—
Louisiana	388.4	1.8	72.8	27.3	0.5	17.2	53.8	1.3
North Carolina	388.3	1.8	74.6	22.1	0.8	15.6	60.1	1.4
Missouri	388.1	1.6	76.2	20.9	0.8	12.3	61.9	4.1
Alabama	327.9	1.5	77.7	29.9	0.5	16.9	52.7	—
Tennessee	324.6	1.5	79.2	25.9	0.8	22.9	49.1	1.2
Virginia	313.4	1.5	80.7	19.7	0.5	12.9	70.0	—
Minnesota	304.5	1.4	82.1	18.6	0.3	11.1	63.0	7.0
Maryland	293.7	1.4	83.5	12.8	0.1	11.0	76.1	0.1
Mississippi	276.3	1.3	84.8	28.5	0.5	10.4	60.2	0.3
Washington	273.6	1.2	86.0	15.0	0.2	12.3	63.4	9.1
Oklahoma	257.6	1.2	87.2	21.3	0.2	9.1	66.7	2.7
South Carolina	247.8	1.1	88.3	23.1	0.7	18.3	56.2	1.6
Indiana	226.4	1.0	89.3	14.3	0.4	11.5	73.8	—
Oregon	225.5	1.0	90.3	8.7	0.5	7.5	70.4	12.9
Connecticut	219.8	1.0	91.3	12.8	0.1	14.6	72.3	0.2
Arkansas	213.4	1.0	92.3	29.6	0.7	18.2	46.0	5.5
Iowa	169.1	0.8	93.1	19.7	0.6	9.9	67.5	2.3
Maine	156.8	0.7	93.8	16.2	0.2	12.5	69.7	1.4
Colorado	150.6	0.7	94.5	21.2	0.2	11.3	58.7	8.6
Kansas	150.0	0.7	95.2	15.1	0.2	9.0	61.2	14.5
District of Columbia	131.3	0.6	95.8	8.5	0.1	10.4	81.0	—
Rhode Island	123.0	0.5	96.3	25.6	0.2	18.8	54.1	1.2
Hawaii	110.2	0.5	96.8	10.6	0.1	6.7	72.6	9.9
West Virginia	104.4	0.5	97.3	24.0	0.5	27.6	47.2	0.6
New Mexico	85.7	0.4	97.7	13.7	0.4	16.3	64.8	4.9
Nebraska	69.4	0.3	98.0	22.3	0.3	12.8	61.5	3.1
Utah	66.5	0.3	98.3	14.2	0.1	10.9	72.5	2.3
Vermont	49.1	0.2	98.5	17.3	0.2	12.7	67.9	1.8
Delaware	44.6	0.2	98.7	8.0	0.2	11.0	80.7[2]	—
New Hampshire	44.0	0.2	98.9	21.2	0.8	10.0	67.8	0.1
Montana	41.9	0.2	99.1	17.7	1.1	14.9	66.2	—
Idaho	41.2	0.2	99.3	16.1	0.2	12.7	68.8	2.2
South Dakota	35.1	0.1	99.4	23.6	0.4	12.7	60.7	2.6
North Dakota	28.8	0.1	99.5	25.5	0.1	9.6	58.5	6.2
Virgin Islands	24.2	0.1	99.6	6.0	0.1	0.9	54.0	39.1
Nevada	21.9	0.1	99.7	23.2	1.4	15.1	60.3	—
Alaska	17.2	0.1	99.8	10.7	0.3	12.6	71.0	5.4
Wyoming	10.8	0.1	99.9	17.6	0.2	9.9	72.3	—

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] Total does not sum to 100% due to rounding.

[2] Includes unknown proportion of Other Title XIX recipients that State was unable to identify separately.

"—" Data not available.

(Z) Percentage less than 0.05.

TABLE 4.6

Distribution of Medicaid Recipients by Jurisdiction, Age, and Sex
Fiscal Year 1979

Medicaid Jurisdiction	Number of Recipients (thousands)	Percentage Distribution by Age and Sex				
		Age [1]			Sex [1]	
		0–20	21–64	65+	Male	Female
All Jurisdictions	21,540.0	47.5%	34.8%	17.5%	34.4%	64.7%
Alabama	327.9	40.6	28.2	31.1	33.5	66.5
Alaska	17.2	—	—	—	—	—
Arkansas	213.4	39.8	27.0	33.2	35.1	64.9
California	3,373.7	45.7	34.7	19.7	31.9	68.1
Colorado	150.6	—	—	—	—	—
Connecticut	219.8	44.8	26.9	13.6	32.3	67.7
Delaware	44.6	60.2	30.6	9.3	33.6	66.4
District of Columbia	131.3	55.3	36.3	8.5	33.7	66.3
Florida	435.8	41.3	28.0	30.3	32.4	67.0
Georgia	401.3	39.8	29.9	30.3	33.9	66.1
Guam	—	—	—	—	—	—
Hawaii	110.2	52.3	37.1	10.7	40.9	59.1
Idaho	41.2	51.7	30.2	18.1	34.2	65.8
Illinois	1,015.8	57.1	32.7	10.2	36.2	63.8
Indiana	226.4	53.0	30.5	16.5	33.7	66.3
Iowa	169.1	48.5	31.5	20.0	35.2	64.8
Kansas	150.0	49.2	32.2	18.7	37.2	62.8
Kentucky	406.8	47.3	31.7	21.0	36.9	63.1
Louisiana	388.4	43.7	28.9	28.5	34.1	65.9
Maine	156.8	42.9	40.9	16.2	—	—
Maryland	293.7	53.1	32.8	14.1	34.7	65.1
Massachusetts [2]	1,046.3	—	—	—	—	—
Michigan	897.7	54.5	34.5	11.0	36.4	63.6
Minnesota	304.5	48.5	32.4	19.1	32.9	62.1
Mississippi	276.3	45.6	25.2	29.2	35.7	64.3
Missouri	338.1	45.3	30.7	24.0	33.9	66.1
Montana	41.9	49.9	30.2	19.2	37.7	61.4
Nebraska	69.4	46.9	30.0	23.1	34.5	64.9
Nevada	21.9	45.2	30.1	24.7	33.0	66.7
New Hampshire	44.0	48.6	30.2	21.2	33.5	66.5
New Jersey	662.7	59.1	30.4	10.6	35.5	64.5
New Mexico	85.7	47.0	31.2	21.8	34.3	61.7
New York	2,364.0	—	—	—	—	—
North Carolina	388.3	43.4	29.9	26.7	33.2	66.8
North Dakota	28.8	49.1	25.3	25.5	36.2	63.8
Ohio	725.8	51.3	36.1	12.6	36.0	64.0
Oklahoma	257.6	51.1	26.1	22.8	35.4	64.7
Oregon	225.5	53.0	36.2	10.7	38.0	62.0
Pennsylvania	1,390.3	47.0	44.4	8.63	38.1	61.9
Puerto Rico	1,424.2	46.2	53.8	—	38.5	61.5
Rhode Island	122.9	43.9	31.2	27.4	33.9	66.1
South Carolina	247.8	41.6	34.5	23.8	22.7	77.3
South Dakota	35.1	45.6	23.7	30.6	35.6	64.4
Tennessee	324.6	37.9	31.8	30.3	34.3	65.7
Texas	681.5	38.6	24.9	36.5	34.3	65.7
Utah	66.5	55.5	29.9	14.6	37.3	62.7
Vermont	49.1	49.1	32.2	18.8	37.2	62.8
Virgin Islands	24.1	54.9	39.1	6.07	36.0	64.0
Virginia [2]	313.4	—	—	—	—	—
Washington	273.6	45.3	40.3	14.4	38.3	61.7
West Virginia	104.4	47.8	35.9	16.3	30.5	63.7
Wisconsin	420.0	50.6	29.7	19.7	37.8	62.2
Wyoming	10.8	—	—	—	—	—

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] Percentages will not always sum to 100% due to unknowns and rounding.

[2] Data on these distributions were received to late for inclusion in this publication from Massachusetts and Virginia.

"—" Data not available.

In addition to the services indicated above, each State may, at its option, choose to provide additional services to its categorically needy population. The provision of any service to the categorically needy does not commit the State to the provision of equal (for example, in amount, scope, or duration) services to the medically needy program. Table 4.7 indicates the optional services covered by each State for either the categorically needy or both the categorically and the medically needy. Optional services are as follows:

1. Medical or other remedial care provided by licensed practitioners within the scope of practice as defined under State law. These practitioners may include among others chiropractors (with limitations), optometrists, and podiatrists.
2. Home health services in addition to the home health services which must be available to persons eligible for SNF services under the State's plan. Home health services, when provided by a licensed agency to a patient in his residence (not including a hospital, an intermediate care facility, or a skilled nursing facility) are defined as the following:

   a) Intermittent or part-time nursing services furnished by a home health agency;

   b) Intermittent or part-time nursing services of a registered professional nurse or a licensed practical nurse under the direction of the patient's physician, when no home health agency is available to provide the nursing services;

   c) Medical supplies, equipment, and appliances recommended by the physician as required in the care of the patient and suitable for use in the home; and

   d) Services of a home health aide, defined as an individual assigned to give personal care services to a patient in accordance with the plan of treatment outlined for the patient by the attending physician and the home health agency that assigns a registered professional nurse to provide continuing supervision of the aide on his or her assignment.

3. Private duty nursing services, defined as nursing services provided by a professional registered nurse or a licensed practical nurse, under the general direction of the patient's physician, to a patient in his or her own home or in a hospital or skilled nursing facility when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or skilled nursing facility.
4. Clinic services, that is, preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of physician or dentist in a facility which is not part of a hospital, but which is organized and operated to provide medical care to outpatients.
5. Dental services, in addition to those required to be provided to persons under 21 years of age in the State's Early and Periodic Screening, Diagnosis, and Treatment program.
6. Physical therapy and related services, including physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, and the use of such supplies and equipment as are necessary when rendered by, or under the supervision of, an individual qualified (licensed, registered, or certified, as appropriate) in the practice of the appropriate profession, and under the prescription or referral of a physician.
7. Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses. Prescribed drugs which may be provided are simple or compounded substances or mixtures of substances prescribed by a physician or other licensed practitioner of the healing arts.
8. Other diagnostic, screening, preventive, and rehabilitative services.
9. Inpatient hospital services, skilled nursing facility services, and intermediate care facility services to persons 65 years of age and over in institutions for tuberculosis or mental disease.
10. Intermediate care facility services, other than services in an institution for TB or mental diseases, for the physically ill or mentally retarded.
11. Inpatient psychiatric hospital services for persons under 21 years of age.
12. Other medical or remedial care recognized under State law. Such additional items and services include transportation, emergency hospital services, personal care services (non-professional) prescribed by a physician and performed under the supervision of a registered nurse in the home, Christian Science sanatoria and nursing services, and skilled nursing facility services for persons under 21 years of age.

State plans which provide for coverage of the medically needy must specify either that all the required services for the categorically needy are also provided for the medically needy, or that the 7 services listed in the required and/or optional services (numbers 1-11) are provided for the medically needy. If inpatient hospital or skilled nursing facility services are included among the services chosen, physicians' services must also be made available to individuals while they are in the hospital or nursing home, even though physicians' services might not otherwise be provided for the medically needy. In addition, if skilled nursing facility services are covered, persons entitled to such services must also be entitled to home health coverage.

Table 4.7 shows the types of optional services covered by each State. Seventy-four percent of the total 54 jurisdictions provide between 9 and 24 optional services, 20 percent provide more than 24, and only 6 percent provide fewer than 9 optional services. Over 90 percent of the 54 States and territories offer prescribed drug services and intermediate care facility services. Prosthetic devices, clinic services, emergency hospital services, intermediate care facility services for the mentally retarded, and skilled nursing facility services for persons under 21 are offered by at least 80 percent of the States. Most other optional services are offered by at least 40 percent of the States. Exceptions are Christian Science nurses and sanitoria, private duty nursing, personal care services, preventive and screening services, and SNF and ICF services for persons age 65 or older in TB institutions.

TABLE 4.7
Medicaid Services By Jurisdiction

● CN[1] + Both CN and MN[1] BASIC REQUIRED MEDICAID SERVICES SEE ABOVE			Practitioners' Services									Drugs and Devices				Outpatient Services					ICFs			SNFs	Personal Services				Services for Age 65 or Older in TB Institutions			Services for Age 65 or Older in Mental Institutions			Total Additional Services	
FMAP[1]			Podiatrists' Services	Optometrists' Services	Chiropractors Services	Other Practitioners Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing and Language Disorder	Rehabilitative Services	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Screening Services	Preventive Services	Diagnostic Services	Clinic Services	Emergency Hospital Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Service for Under Age 22	SNF for Under Age 21	Personal Care Services	Private Duty Nursing	Christian Science Nurses	Christian Science Sanitoria	A Inpatient Hospital Services	B SNF Services	C ICF Services	A Inpatient Hospital Services	B SNF Services	C ICF Services		
71	●	Alabama		●								●		●	●						●	●	●	●											12	AL
50	●	Alaska		●						●					●				●	●	●	●	●	●								●			10	AK
61		Arizona																																		AZ
73	+	Arkansas		+	+	+	+					+	+	+	+				+	+	●	●	+	●				+	●	●	+	●	●	21	AR
50	+	California	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+	+	+	+	30	CA
50	●	Colorado	●									●		●					●	●	●	●	●	●							●	●	●	12	CO
50	+	Connecticut	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+		+		+			+			24	CT
50	●	Delaware	●									●		●				●	●	●	●	●		●							●			10	DE
50	+	D C	+	+		+		+			+	+		+	+		+	+	+	+	+	+	+	+	+			+			+			19	DC
59	●	Florida		●		●	●			●		●	●		●					●	●	●	●	●				●	●			●			14	FL
67	●	Georgia	●			●						●		●					●		●	●		●				●	●	●		●	●	13	GA
50	+	Guam		+			+	+		+		+	+	+	+				+	+														10	GU
50	+	Hawaii	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+										20	HI
66	●	Idaho	●	●	●			●			●	●							●	●	●	●		●									●	12	ID
50	+	Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+	+	+			+		+	+	+	+	+	+	29	IL
57	●	Indiana	●	●	●		●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●		●	●	●			●			24	IN
59	●	Iowa	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●		●	●	●	●	●							●			21	IA
54	+	Kansas	+	+	+	+	+	+	+	+	+	+	+	+	+				+	+	+	+	+	+		+			+	+	+	+	+	+	26	KS
68	+	Kentucky		+		+		+	+	+		+		+					+	+	+	+	+	+					+			+	+	+	17	KY
69	+	Louisiana			+						+	+	+	+					+	+	●	●	●	●					●			●	●	●	15	LA
70	+	Maine	+		+	●		+	+	+	+	+		+		+	+	+	+	●	+	+	+	+			+	+				+	+	●	23	ME
50	+	Marylgnd	+	+				+				+	+	+	+				+	+	+	+		+					+					+	15	MD
52	+	Massachusetts	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+	+	+			+	+	+	28	MA
50	+	Michigan	+	+	+	+	+	+	+	+		+	+	+	+				+	+	+	+	+	+	+			+				+	+	+	24	MI
56	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+	+	+	+	31	MN
78	●	Mississippi					●					●									●	●		●				●			●				8	MS
60	●	Missouri		●			●				●	●	●		●	●	●	●		●	●	●						●			●				14	MO
64	+	Montana	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+						+	+	+	26	MT
58	+	Nebraska	+	+	+	+	+	+		+	+	+	+	+	+				+	+	+	+	+		+	+						+	+	+	23	NB
50	●	Nevada	●	●	●	●		●	●	●	●	●	●	●	●				●	●	●	●			●	+	●						●			20	NV
61	+	New Hampshire	+	+	+	+		+	+	+	+	+		+	+	+	+	+	+	+	●	●			+	+	+	+					+		●	25	NH
50	●	New Jersey	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			●	●			●	●	●	27	NJ
69	●	New Mexico	●	●		●	●	●	●	●	●	●	●	●	●				●	●	●	●		●		●									18	NM
50	+	New York	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	+	+	+	+	29	NY
68	+	North Carolina	+	+	+		+				+	+	+	+	+	+	+	+	+		+	+	+	+				+			+		+	19	NC
51	+	North Dakota	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+		+					+			22	ND
50	+	N. Mariana Islands		+			+	+				+	+	+	+				+	+			+	+	+			+	+			+			16	NMI
55	●	Ohio	●	●	●	●	●	●	●	●		●	●	●	●				●	●	●	●	●	●		●				●		●	●	●	23	OH
64	+	Oklahoma	+								+	+		+							+	+	+		+							+			10	OK
56	●	Oregon	●	●	●	●	●	●			●	●	●	●	●			●	●	●	●	●	●	●	●	●		●				●			22	OR
55	+	Pennsylvania	●	+	+		●					●	●	●					+	+	+	+	+									+	+	+	16	PA
50	+	Puerto Rico				+	+	+	+	+	+	+				+	+	+	+	+									+						13	PR
58	+	Rhode Island	+	+			+					+	+	+	+						●	●			+							+			11	RI
71	●	South Carolina	●		●							●		●					●	●	●	●	●	●					●			●			11	SC
69	●	South Dakota			●		●	●	●		●	●	●	●					●	●	●	●		●	●								●	●	16	SD
69	+	Tennessee										+		+					+	+	+	+	+					+	+	+	+	+	+	+	14	TN
58	●	Texas	●	●	●						●	●		●	●					●	●	●			●			●	●						13	TX
68	+	Utah	+	+		+	+	+		+		+	+	+					+	+	+	+	+	+		+					+				18	UT
68	+	Vermont	+									+		+					+	+	+	+	+	+								+			10	VT
50	+	Virgin Islands					+	+	+	+		+	+	+	+																				9	VI
57	+	Virginia	+	+				+	+	+		+		+					+	+	+	+		+				+	+			+	+	+	17	VA
50	+	Washington	+	+	+	+	+	+		+	+	+	+	+	+		+	+	+	+	+	+	●	+		+			+	+	+	+	+	+	27	WA
67	+	West Virginia	+	+	+	+		+		+		+	+	+	+				+	+	+	+		+		+			+	+		+	+		20	WV
58	+	Wisconsin	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+					+			27	WI
50	●	Wyoming		●				●			●			●							●			●												6	WY
●	20	●	14	14	10	9	11	10	7	7	11	19	11	16	12	3	4	6	12	18	24	23	12	19	4	5	1	1	9	2	2	14	8	11		
+	34	+	25	27	17	20	23	26	18	23	20	33	24	30	26	13	16	17	32	28	26	25	22	27	12	14	5	11	17	9	7	29	17	16		
	54	Total	39	41	27	29	34	36	25	30	31	52	35	46	38	18	20	23	44	46	50	48	34	46	16	19	6	18	26	11	9	43	25	27		

[1] FMAP-Federal Medicaid Assistance Percentage Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act Percentages effective from October 1, 1979, through September 30, 1981 are rounded

[2] Categorically Needy People receiving federally supported financial assistance

[3] Medically Needy People who are eligible for medical but not for financial assistance

Once a State has selected a benefit package, Federal regulations require that the State plan specify the amount and/or duration of each item of medical and remedial care and services that will be provided. Such items must be sufficient in amount, duration, and scope to reasonably achieve their purpose, and limits may not be imposed on the basis of "diagnosis, type of illness, or condition." States have considerable flexibility to set limits within these requirements.

Table 4.8 displays the limitations States impose on four mandatory services and two optional services. Both inpatient hospital services and physicians' services have limitations in 42 States. These limitations range from preauthorization requirements to a ceiling on the number of covered benefit days or visits. SNF benefits and outpatient hospital benefits have limitations in 30 and 31 States, respectively. Half of the 50 jurisdictions offering ICF benefits impose limitations on those benefits, frequently in the form of preauthorization requirements. Prescription drug services are offered by all jurisdictions with the exception of Alaska and Wyoming. Of the 52 jurisdictions offering drug services, 48 impose some type of limitation on them, frequently through restricted formulary lists.

With the passage of the Social Security Amendments of 1972 (P.L. 92-603), States were empowered to impose nominal cost sharing requirements on optional Medicaid services for cash assistance recipients, and on any services for the medically needy. Seventeen States have used this copayment option. Table 4.9 describes the cost sharing features of these 17 State Medicaid programs. Of the 17, 15 require copayments on prescriptions, 6 on vision services, 3 on dental services, 2 on orthotic and prosthetic services, and 3 on other services (for example, podiatry, chiropratic). In addition to the cost sharing requirements described in the table, all States require Medicaid patients in long-term care institutions to contribute their "excess" income (usually defined as all income over $25 per month allotted for personal needs) to the cost of their care.

Table 4.10 presents the changes in Medicaid coverage by jurisdiction for the time period January-June 1980. These changes are only the reported State plan changes and do not include changes that have not been officially reported to HCFA pending Regional/State negotiations or State legislative action, or simply have not been filed by the States with HCFA.

D. Utilization

This section presents data on the use of medical services by Medicaid recipients. For each jurisdiction, tables show the distribution of Medicaid recipients by type of medical service; actual number of recipients and volume of services for general hospitals, SNFs, ICFs, physicians, and drug prescriptions; EPSDT screenings and conditions found; and number and types of sterilization procedures. Recipient counts for each type of service are unduplicated. But it should be noted that one recipient may have received more than one type of service, for example, a single recipient could have used inpatient hospital services, physicians' services, and outpatient hospital services. Thus, the total number of recipients will not be equal to the sum of recipients receiving each service.

In addition, Medicaid utilization estimates do not include a population at risk as do the Medicare rates presented in Chapter III. As a result, they represent average use by those actually using services rather than rates of use among Medicaid eligibles. (No national counts of Medicaid eligibles as opposed to recipients are available at the present time, although work is in progress to develop an unduplicated count of eligibles. Preliminary Medicaid use rates should be available by late 1981 or early 1982.)

Table 4.11 displays total recipients by jurisdiction for fiscal year 1979 and the proportions of recipients within each jurisdiction using specific services. Since a recipient can receive more than one service, percentages are expressed as a percent of total recipients. More recipients used physicians' services than any other service.

The distribution of all Medicaid recipients in the nation, by type of medical service, and by recipient's age and sex, is shown in Table 4.12. Data are for fiscal year 1979. Recipients under age 20 were the most frequent users of dental services, physicians' services, outpatient hospital services, clinic services, and prescribed drugs. Recipients age 65 and over were the most frequent users of skilled nursing facility services and intermediate care facility services. Family planning services, other care, laboratory and radiological services, other practitioner services, inpatient hospital services, and home health services were used most frequently by the 21-64 age group. All services were used predominantly by females.

Table 4.13 presents statistics on recipients and services used by jurisdiction for general hospitals, SNFs, ICFs (other than for mental retardation), physicians, and drug prescriptions. For general hospitals, total discharges are a duplicated count of recipients who have been discharged, while recipients discharged are an unduplicated count. A day of care in general hospitals, SNFs or ICFs is counted only if paid for in whole, or in part, by Medicaid. Thus, it is impossible to derive the average length of stay for Medicaid patients. It should be noted that discharges from tuberculosis hospitals are included with those from general hospitals.

A physician visit is a consultation with a physician or a person acting under the physician's supervision. When a physician's bill does not show visits but simply a flat fee, the recipient is reported as receiving physicians' services but the number of visits is not reported. The number of prescriptions is a count of each prescription, including refills. However, drugs provided for inpatients (in hospitals or other institutions) are excluded.

Table 4.14 displays comparative data for EPSDT recipients under age 21 and under age six years for each State. The number of screenings are detailed. Screening is defined as the use of procedures to distinguish apparently well persons from persons who may have a disease or abnormality, and to identify persons in need of more definitive study of their physical or mental problems. Of the more than 2 million recipients screened, approximately one-half were under age six. Numbers of screenings varied considerably across States. However, these data are not reported in rate form and, therefore, do not take account of population differences.

Table 4.14 also shows percentages of recipients screened with at least one suspected condition. For all reporting States, the percentage of individuals under age six with at least one suspected condition is 43.1. When ages up to 21 are also included, the percentage rises only 8.2 percentage points to 51.3 percent.

TABLE 4.8

Limitations on Selected Services in the Medicaid Program by Jurisdiction December 1980

Medicaid Jurisdiction and Services	
Alabama	
Inpatient Hospital Services	15 days per calendar year unless extension is authorized. No Friday or Saturday admissions except emergencies.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required.
Physicians' Services	For stable, chronic illness: 1 visit per day in hospital, 1 visit per month elsewhere.
Outpatient Hospital Services	6 per calendar year unless authorized; limitation does not apply to emergencies or maintenance procedures such as dialysis or chemotherapy.
Prescription Drugs	Drugs not listed in Alabama Drug Code Index require preauthorization.
Alaska	
Inpatient Hospital Services	Preauthorization required for non–emergency out–of–state hospitalization.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required.
Physicians' Services	Preauthorization required for elective (cosmetic) surgery.
Outpatient Hospital Services	No limitations.
Prescription Drugs	No Medicaid coverage for prescription drugs.
Arkansas	
Inpatient Hospital Services	26 days per calendar year; extensions must be authorized. For dually–entitled persons, Medicaid hospital days counted concurrently with Medicare.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required.
Physicians' Services	18 visits per calendar year in physician's office, patient's home or nursing home; 12 visits per year for hospital emergency rooms. Preauthorization required for surgical procedures considered to be elective.
Outpatient Hospital Services	12 visits per calendar year.
Prescription Drugs	Limit of 4 prescriptions per month with maximum supply for one month. Amphetamines and anti–obesity drugs not covered.
California	
Inpatient Hospital Services	Subject to preauthorization and specified length of stay as approved.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Subject to preadmission authorization and periodic reauthorization.
Physicians' Services	Subject to preauthorization for more than 8 psychiatric visits or 8 allergy hyposensitization visits in a 120–day period. Services for cosmetic purposes not covered. Preauthorization required for sterilization services.
Outpatient Hospital Services	Subject to limitations and contracts established for the particular service being rendered.
Prescription Drugs	Prescribed drugs not listed in program's drug formulary subject to preauthorization. Prescription quantities limited to 100 days' supply; discharge medications limited to 10 days' supply.

(continued)

Medicaid Jurisdiction and Services	
Colorado	
Inpatient Hospital Services	Services provided as long as is medically necessary. Emergency hospital services provided when necessary to prevent death or serious impairment of health, even though hospital may not meet conditions for participation under Title XVIII.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	No limitations.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Coverage excludes: dietary needs, food supplements, personal care items; drugs used to treat drug addiction; drugs classified by DHHS as 'investigational', experimental' or 'ineffective'; prescriptions by dentists for prophylactic purposes; over-the-counter drugs, medical supplies and other non-prescription items.
Connecticut	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Level of care is determined within 14 days of the patient's admission to the facility and the need for continued care in the facility is periodically redetermined thereafter.
Physicians' Services	For hemodialysis service, preauthorization required for first 3 months and reauthorization every 6 months.
Outpatient Hospital Services	Preauthorization required for special services beyond clinic visit such as speech, hearing and physical therapy services.
Prescription Drugs	Vitamins, other than a single vitamin, for a deficiency, are limited to pregnant women and children under 7.
Delaware	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	No limitations.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Drugs which can be purchased wihtout prescription not covered. Anoretic drugs covered only if documented as medically necessary for the treatment of hyperactivity or certain sleep disorders.
District of Columbia	
Inpatient Hospital Services	Preauthorization required for services provided in connection with surgical procedures for cosmetic purposes except for emergency repair of accidential injury. Dental or oral surgery services limited to those required for emergency repair of accidental injury to the jaw and related structures.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Items and services furnished by a skilled nursing home maintained primarily for the care and treatment of in-patients with tuberculosis will be provided only for individuals 65 years of age or older. ICF—no limitations.
Physicians' Services	Elective procedures requiring general anesthesia will be provided only when performed in a facility accredited for such procedures. Preauthorization required for surgical procedures for cosmetic purposes except for emergency repair of accidential injury. Ambulatory psychiatric care will be provided only in a state approved psychiatric clinic except when prior authorization for such care has been obtained from state agency.

(continued)

Medicaid Jurisdiction and Services	
District of Columbia (Continued)	
Outpatient Hospital Services	Preauthorization required for surgical procedures for cosmetic purposes except for emergency repair of accidental injury. Dental or oral surgery services limited to the emergency repair of accidental injury to the jaw and related structures.
Prescription Drugs	Items and services are defined and limited to those included in the D.C. Pharmacy Formulary and in the Revisions to the Formulary.
Florida	
Inpatient Hospital Services	45 days per patient per fiscal year, excludes organ transplants which are considered experimental, clinically unproven procedures, cosmetic surgery, routine physicals and eye examinations, sterilization and abortion procedures except for those meeting federal requirements and surgical procedures classified as elective.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	Visits outside of hospital limited to 3 per month; consultations limited to 1 per medical specialty per recipient per illness. Excludes internal organ transplants which are considered experimental, cosmetic surgery, routine eye examinations, sterilization procedures except for those meeting federal requirements and surgical procedures classified as elective.
Outpatient Hospital Services	Maximum of $500 per patient per fiscal year.
Prescription Drugs	Drugs in excess of $22 per month per recipient or $33 per month per recipient in skilled nursing or intermediate care facilities must be approved. Excluded are drugs provided through other programs, prosthesis, personal care items, drugs for hospitalized patients, oxygen, blood or blood plasma, nonlegend drugs except prescribed insulin, antiobesity drugs unless prescribed for purposes other than weight control and vitamin preparations prescribed as tonic or dietary supplements.
Georgia	
Inpatient Hospital Services	Preauthorization required for tonsillectomies, adenoidectomies, keloid removal, physical therapy exceeding 24 treatments, osteopathic manipulative therapy, nonemergency renal dialysis, and kidney transplants. Private duty nursing and private rooms are not covered.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required.
Physicians' Services	Maximum of $250 per patient per year for outpatient psychiatry. Unless medically justifiable need exists, home and office visits limited to 1 per month, nursing home visits limited to 1 per month, and hospital visits limited to 1 per day.
Outpatient Hospital Services	1 visit per month except in emergency situations, acute or chronic illness, necessary referrals, and follow-up visits associated with same diagnosis. No limitation on EPSDT or family planning services.
Prescription Drugs	Quantity for any prescription or refill limited to one month's supply. Drugs authorized for reimbursement are listed in the Medical Assistance Program Drug List and the Controlled Medical Assistance Drug List. Unlisted drugs require prior approval.
Guam	
Inpatient Hospital Services	Medicaid recipient may not be confined for more than 65 consecutive days at semi-private rate. For confinement medically necessary after this time period, a reduced room rate equal to a SNF must be utilized. Only 1 SNF must be utilized. Only 1 doctor's visit per day except for intensive care or consultation. Only 3 pints of blood.

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Medicaid Jurisdiction and Services	
Guam (Continued)	
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFs—No limitations. ICFs—Not provided.
Physicians' Services	2 visits per week in SNF. Transportation cost of physician not covered.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Each supply of a prescribed drug shall constitute one prescription. Quantities not to exceed 100 days' supply; quantities furnished on inpatient discharge not to exceed 10 days' supply. Food supplements (except protein replacement), milk modifiers, infant formulas, therapeutic diets, and experimental drugs not covered.
Hawaii	
Inpatient Hospital Services	Hospital admissions authorized for following number of days: medical and surgical, 8; confinement and delivery, 4; T&A, 2; and psychiatric, 10. Approval for extension is required for additional days, limited to 18 days for psychiatric care. Preauthorization required for any nonemergency admissions.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required.
Physicians' Services	For patients in skilled nursing facilities, limited to 2 visits per month except during acute episodes when additional visits are authorized.
Outpatient Hospital Services	Psychiatric services are initially authorized for 4 visits during a 12 month period. Additional visits may be provided following approval of extension request.
Prescription Drugs	Drugs of experimental nature excluded from program.
Idaho	
Inpatient Hospital Services	Limited to 40 days per admission. Length of stay subject to professional review for appropriateness and necessity but will not exceed 40 days.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	Abortions and related services provided only if recommended by 2 consulting physicians who state that it is necessary to save the life of the mother, 2 consulting physicians' recommendations that the mother will suffer severe and long lasting physical damage if fetus is carried to term; that in the case of rape or incest, the incident is reported promptly to a law of enforcement or public health agency and the pregnancy is a result of rape or incest is determined by the courts.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Limit of $35 per month per recipient excluding oral contraceptives and diaphragms. Amphetamines and related medications and certain therapeutic vitamins formerly covered are excluded.
Illinois	
Inpatient Hospital Services	Maximum of 45 inpatient days per year. Psychiatric services limited to an initial period of 10 days and a possible 10 day extension with approval.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	No limitations.

(continued)

Medicaid Jurisdiction and Services	
Illinois (Continued)	
Outpatient Hospital Services	No limitations.
Prescription Drugs	As described in the Department's Drug Manual or approved by the Department's Committee on Drugs and Therapeutics.
Indiana	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	No limitations.
Outpatient Hospital Services	No limitations.
Prescription Drugs	No limitations.
Iowa	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	No limitations.
Outpatient Hospital Services	No limitations.
Prescription Drugs	No limitations.
Kansas	
Inpatient Hospital Services	All out–of–state inpatient care is subject to prior authorization except for emergency care and care within hospitals bordering Kansas whose services are routinely used by Kansas recipients. No payment will be made for inpatient admissions from midnight Thursday through midnight Sunday except in case of emergency admission. Documentation of medical necessity required for abortions.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	Unless there is written documentation confirming medical necessity, visits are limited to: 1 per month for adult care home visits and 3 office visits per month for psychiatric services. Non–life endangering psychiatric problems require preauthorization. Documentation of medical necessity required for abortions. Surgery for cosmetic purposes not payable.
Outpatient Hospital Services	In hospital follow–up provided if services can't be provided at a lesser facility. Outpatient emergency services must be documented as medically necessary. Psychiatric services provided upon agreement outlining services to be provided. Agreement with hospital required for physical rehabilitation services and outreach nursing services for the terminally ill. Documentation of medical necessity for required abortions.
Prescription Drugs	Maximum quantity for a single prescription is a 100–days' supply. Non–legend items covered when prescribed for specific conditions. Excludes: anoretics; maintenance formula vitamin products except pediatric formulations; single entity vitamin E products unless exceptional hardship is documented or medical need justified by prescribing physician; topical antiseptic and first aid formulations; routine feminine hygiene products; laxatives and stool softeners; and suntan accelerators and sunscreen products.

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Medicaid Jurisdiction and Services	
Kentucky	
Inpatient Hospital Services	21 days per admission; approval required for stays beyond 7 days. Abortion services require documentation of medical necessity.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required to be reevaluated.
Physicians' Services	Certain initial and extensive visits limited to 2 per patient per physician per year. Patients 'locked in' to 1 physician due to over utilization may receive services only from that physician except in case of an emergency or referral.
Outpatient Hospital Services	Limited to therapeutic and diagnostic services ordered by physician and emergency situations requiring ER services. Abortion services require documentation of medical necessity.
Prescription Drugs	Limited to drugs on restricted formulary list; unlisted drugs require preauthorization. Practitioner authorization required for prescriptions refilled up to 5 times in 6 months. Patients 'locked in' to 1 pharmacy due to overutilization may receive services only from that pharmacy except in cases of emergency or referral.
Louisiana	
Inpatient Hospital Services	Care in a short term general hospital limited to 15 days per calendar year without preauthorization. If a recipient requires hospitalization beyond 15 days or readmission when medically necessary home passes are required, a determination to extend hospitalization would be made.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	Limited to 12 outpatient visits per year with extensions subject to prior approval. Up to 15 inpatient hospital visits including admission visits in any calendar year when recipient is hospitalized without surgery.
Outpatient Hospital Services	3 visits per year.
Prescription Drugs	Restricted formulary list; if a specified brand is necessary must be certified by prescriber.
Maine	
Inpatient Hospital Services	Preauthorization required for stays beyond 60 days excluding stays for intensive care and coronary care services.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	No limitations.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Restricted formulary list; prescriptions limited to 180 days' supply.
Maryland	
Inpatient Hospital Services	Preauthorization required for cosmetic surgery, transplantation of vital organs, lipectomy, panniculectomy, and all services related in any way to sex reassignment.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required.
Physicians' Services	Preauthorization required for cosmetic surgery; contact lens evaluation and fitting; refractions for the purpose of prescribing eyeglasses; consultations provided by radiologists or pathologists; transplantation of vital organs; lipectomy and panniculectomy; and all services related in any way to sex reassignment.

(continued)

Medicaid Jurisdiction and Services

Maryland (Continued)	
Outpatient Hospital Services	Preauthorization required for cosmetic surgery, lipectomy, and all services related in any way to sex reassignment.
Prescription Drugs	Limit of 2 refills per prescription which must be dispensed by original provider. Total treatment time covered by original prescription and its refills may not exceed 100 days except for birth control pills which are limited to a 6 cycle supply. Non–legend drugs other than insulin and schedule 5 cough preparations are not covered. Preauthorization required for any prescription with an ingredient cost exceeding $20.
Massachusetts	
Inpatient Hospital Services	Second opinion required for elective operations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	Designed elective surgical procedures require qualified and independent judgments concerning deferrability of the surgery.
Outpatient Hospital Services	No limitations.
Prescription Drugs	No limitations.
Michigan	
Inpatient Hospital Services	Admission and continued stay must be medically necessary and certified by area Professional Standards and Review Organization.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Minimum period necessary in this type facility for proper care and treatment of the patient. ICF— preauthorization required.
Physicians' Services	Nursing home visits limited to one visit per month per patient; additional visits must be documented as medically necessary. Speech/language evaluations limited to two per year.
Outpatient Hospital Services	Routine examinations not covered.
Prescription Drugs	Covered when prescribed in writing by a licensed practitioner. (Restricted formulary implemented February 1981.)
Minnesota	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	No limitations.
Outpatient Hospital Services	No limitations.
Prescription Drugs	No limitations.
Mississippi	
Inpatient Hospital Services	20 days per fiscal year.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required. Not authorized for medically needy.
Physicians' Services	Hospital visits limited to one per day except ICU or CCU patients who are limited to two per day. Nursing home visits limited to 36 visits per fiscal year. Physician services in office, outpatient.
Outpatient Hospital Services	6 ER visits per year. Hospital outpatient clinic visits limited to 12 per fiscal year.
Prescription Drugs	Limited to drugs listed in a printed formulary.

(continued)

TABLE 4.8 (continued)

Medicaid Jurisdiction and Services

Missouri	
Inpatient Hospital Services	21 days per admission.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization for recipients 21 years or older in SNFs and recipients 65 or older in state mental institutions; duration conditional upon periodic, subsequent recertification. ICFs preauthorization required.
Physicians' Services	Limited to 3 per provider for each recipient per month.
Outpatient Hospital Services	Services limited to those that are medically necessary.
Prescription Drugs	Limited to drugs contained on Missouri's limited formulary.
Montana	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	No limitations.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Over–the–counter items not requiring a prescription are not ordinarily covered.
Nebraska	
Inpatient Hospital Services	Psychiatric care after 24–hour emergency limited to facility licensed for psychiatric care.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFs—No specified limitations. ICFs—preauthorization required.
Physicians' Services	Influenza injections given by physician to patients in ICF–1 nursing homes not covered. Payment may not be authorized for: medical procedures or drugs considered experimental; reversal of tubal ligations or vasectomies or sex change operations. Abortions limited to those deemed necessary to the professional judgment of woman's attending physician.
Outpatient Hospital Services	Drugs, medical supplies and services not utilized in ER or OP facility are not authorized.
Prescription Drugs	Limited to legend and over–the–counter drugs provided for preventative, therapeutic or remedial treatment.
Nevada	
Inpatient Hospital Services	Limited to admissions designated in the Concurrent Review Screening Manual.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required.
Physicians' Services	Limited to 2 office visits per person per month for treatment of illness, 2 therapeutic injections per month and emergency treatment. Family planning and hospital inpatient services not limited.
Outpatient Hospital Services	Subject to same limitations as physician services.
Prescription Drugs	Limited to 3 prescriptions per month and those a physician designates as 'emergency'; family planning supplies not limited.
New Hampshire	
Inpatient Hospital Services	The PSRO evaluates appropriateness of care and length of stay determinations; payment made only for PSRO approved days. For hospitalizations in designated out–of–state border hospitals, preauthorization required for stays anticipated to be longer than 12 days. Preauthorization required for services in all out–of–state hospitals other than border hospitals.

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Medicaid Jurisdiction and Services	
New Hampshire (Continued)	
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required. SNFS—utilization review required at least once each 30 day period. ICFs—physician must file recertification of patient's need for intermediate nursing care at least each 60 days.
Physicians' Services	Physician visits limited to: 1 per month for nursing home patients; 1 per week for SNF patients; and 1 per provider per day for inpatient visits. Preauthorization required for services of physicians practicing outside New Hampshire. Psychiatric care by licensed psychiatrist limited to a maximum of $500 per patient per fiscal year.
Outpatient Hospital Services	Preauthorization required for out–of–state hospital services.
Prescription Drugs	Anorectic drugs covered only for treatment of narcolepsy and hyperkinetic children. Children's regular and flouride vitamins covered for children through age 6. Nicotinic acid or its amide covered only when prescribed for treatment of peripheral vascular disease.
New Jersey	
Inpatient Hospital Services	Excludes elective cosmetic surgery and diet therapy for exogenous obesity.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required except where patient is transferred directly from an acute care hospital, class 'A' special hospital, or NJ Title XIX certified psychiatric hospital.
Physicians' Services	Preauthorization required for elective cosmetic surgery and for psychiatric services exceeding $300 in any 12 month period.
Outpatient Hospital Services	Excludes elective surgery. Need for services which involve an extended course of treatment must be certified and recertified.
Prescription Drugs	Limit of 60 days supply per prescription with not more than 2 refills in a 6–month period; for oral contraceptives limited to initial 3 month supply with 2 refills in a 9 month period. Preauthorization required for: injectibles (except insulin and prescribed medications provided for patients in long–term care facilities); vitamins for persons age 6–65, antiobesics/anorexics; and for oral antibiotic and anti–infective agents prescribed for more than 10 days.
New Mexico	
Inpatient Hospital Services	Abortion services require documentation of medical necessity. Payment for private rooms limited to patients requiring isolation.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	2 hospital vists per day per person. Abortion services require documentation of medical necessity. Allergy testing and treatment allowable only when urgently needed and preauthorized by PSRO.
Outpatient Hospital Services	Abortion services require documentation of medical necessity. Allergy testing and treatment is allowable only when urgently needed and preauthorized by PSRO.
Prescription Drugs	Flu and pneumococcal vaccines limited to persons 65 or over, or persons suffering from chronic cardiac or pulmonary disease. Most legend drugs covered, some drug items require preauthorization. All non–legend drugs require preauthorization except salicylates and acetaminophen, antacids, vitamin drops for infants up to 1 year old, insulin and ferrous salts as single entity drugs.

(continued)

Medicaid Jurisdiction and Services

New York	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFs—preauthorization required except when admitted directly from a hospital, another nursing home, or from a health related facility. ICFs—no limitations.
Physicians' Services	No limitations.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Restricted formulary list.
North Carolina	
Inpatient Hospital Services	PSRO will certify length of stay at time of admittance. Preauthorization required for cosmetic surgery and surgical transplants except bone, tendon, and renal transplants.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFs—preauthorization required. ICFs—if Independent Professional Review Team recommends a change in level of care, these recommendations will be accepted.
Physicians' Services	Routine physicals and screening tests excluded except for EPSDT, SNF and ICF recipients. Routine immunizations excluded except for EPSDT recipients. Abortions require certification of medical necessity.
Outpatient Hospital Services	Preauthorization required for more than 2 visits for psychiatric treatment. Routine physicals and routine immunizations not covered except for EPSDT. Injections not covered if oral medications are suitable.
Prescription Drugs	Limited to legend drugs and insulin. Generic drugs will be dispensed unless prescriber indicates ' dispense as written.'
North Dakota	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	No limitations.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Excludes prescribed diet remedies and alcoholic beverages.
Northern Marianas	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFs—no limitations. ICFs—not provided.
Physicians' Services	Visits limited to 1 per day for inpatient stays except for ICU or CCU patients; 2 per week to patient's home or SNF; and 3 per week for psychiatric facility patients unless additional visits are requested by psychiatric director.
Outpatient Hospital Services	Occupational therapy not covered.
Prescription Drugs	No limitations.

(continued)

Medicaid Jurisdiction and Services

Ohio	
Inpatient Hospital Services	60 day limitation per spell of illness.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFs--physician certification and recertification required every 60 days. ICFs--no limitations. Person must be in need of such care.
Physicians' Services	10 physician visits per month.
Outpatient Hospital Services	Limited to 4 per month without preauthorization.
Prescription Drugs	Prescriptions not to exceed 34–day supply or 100 dosage units, whichever is greater. Preauthorization required for dietary supplements.
Oklahoma	
Inpatient Hospital Services	10 days per admission.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required.
Physicians' Services	Visits limited as follows: inpatient, 1 per day; outpatient, 4 office and/or home visits per month regardless of number of physicians; and nursing home, 2 visits per month.
Outpatient Hospital Services	Limited to services provided within 24 hours following an acute physical injury; dialysis and therapeutic radiology or thermography for proven malignancy.
Prescription Drugs	Maximum of 3 prescriptions (new or refill) per month; quantities limited to a 34 day supply of 100 dosage units whichever is greater. Only legend drugs in designated categories provided.
Oregon	
Inpatient Hospital Services	Limited to 21 days.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	Preauthorization required for selected elective and rehabilitative procedures.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Prescribed drugs are provided subject to items and cost listed in published formulary.
Pennsylvania	
Inpatient Hospital Services	Payment is not made for prolonged hospitalization which is not medically justified nor for overnight or weekend passes in excess of 12 hours continuous absence.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	Limit of 1 general medical exam and 1 allergy survey per year. Office visits for chronic conditions limited to 3 per month. Inpatient consultations limited to 1 per specialty per hospitalization; outpatient consultations limited to 1 per specialty per 12 month period.
Outpatient Hospital Services	Maximum of 3 visits per month for chronic illness. Prenatal care visits limited to 12 except in cases of pregnancy complications. Preauthorization required for all general and special medical examinations.
Prescription Drugs	Preauthorization required for all prescribed medication for which total charge exceeds $15. Maximum of 45 day supply except for prescriptions of anovulatory drugs; these are compensable up to a maximum supply of 3 cycles if cost does not exceed $15.

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Medicaid Jurisdiction and Services	
Puerto Rico	
Inpatient Hospital Services	Limited to services provided in public facilities and 2 private facilities under contract.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFS—provided in public facilities. No federal financial participation claimed. ICFs—not provided.
Physicians' Services	Available through public facilities and some physicians under contract.
Outpatient Hospital Services	Limited to services provided in public facilities and 2 private facilities under contract.
Prescription Drugs	Limited to drugs dispensed through pharmacies of publicly operated facilities.
Rhode Island	
Inpatient Hospital Services	Preauthorization required for stays in excess of 15 days per admission for persons under age 65, or in excess of 60 days for persons age 65 or older who are also covered by Medicare.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required.
Physicians' Services	Preauthorization required for: visits in excess of 2 per month for chronic illness; visits in excess of 8 per month for acute illness; inpatient hospital visits in excess of 37 days up to a maximum of 100 days; and for psychiatric office visits beyond initial evaluation visit.
Outpatient Hospital Services	Preauthorization required for speech therapy and physical therapy.
Prescription Drugs	Preauthorization required for central nervous system stimulants, appetite depressants, injectibles (except insulin and adrenalin which are self-administered) and certain expensive drugs.
South Carolina	
Inpatient Hospital Services	Experimental internal organ transplants, unproven procedures, cosmetic plastic surgery, and other procedures determined not to be medically necessary are not covered. Certain procedures require preauthorization.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	PSRO must approve payment.
Physicians' Services	Office visits limited to 1 comprehensive exam per patient per fiscal year and 1 intermediate exam per patient every 4 months. Additional office and home visits must have proper justification. One hospital visit per day per patient. Unless justified, SNF visits limited to 1 limited exam per 30 days and ICF visits to 1 limited exam per 60 days. Experimental internal organ transplants, unproven procedures, and cosmetic plastic surgical procedures not included.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Limited to drugs listed in the Medicaid Formulary with the exception of drugs on a preauthorized basis for specific circumstances.
South Dakota	
Inpatient Hospital Services	60 days per benefit period and 3 pints of blood per benefit period.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	Routine physical exams not covered without preauthorization.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Limited to legend drugs and biologicals with exception of some specific drugs.

(continued)

TABLE 4.8 (continued)

Medicaid Jurisdiction and Services	
Tennessee	
Inpatient Hospital Services	Limited to 20 days per fiscal year.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFS—preauthorization required. ICFs—no limitations.
Physicians' Services	Preauthorization required for unusual elective types of surgical procedures.
Outpatient Hospital Services	Limited to 30 visits per fiscal year.
Prescription Drugs	Drugs listed in a formulary with exception of anorectics (allowed for narcolepsy and hyperkinesis), compounded prescriptions, non-narcotic analgesic compounds, specific expensive psychotropic and antibiotic drugs.
Texas	
Inpatient Hospital Services	Up to 30 days per illness if medically necessary.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Physician provides prescription for level of care setting and state agency provides level of care determination for which payment will be made.
Physicians' Services	No limitations.
Outpatient Hospital Services	No drugs and biologicals which can be self-administered. Occupational therapy limited to treatment designed for independent functioning.
Prescription Drugs	Original prescriptions must be presented within 10 days. Up to five refills may be authorized if dispensed within six months or date of original prescription. All drugs covered must be under the Vendor Drug Program and appear in the latest revision of the Texas Drug Code Index and supplements.
Utah	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	Preauthorization required for procedures that are medically unproven or are for cosmetic purposes.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Preauthorization required for most minor tranquilizers. Vitamins limited to prenatal and those for children up to five years. Medication for appetite suppression not included.
Vermont	
Inpatient Hospital Services	Dental services limited to surgical procedures and those preauthorized. Private room at patient's request, personal comfort items, private duty nurses, and experimental treatment procedures are not covered.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Preauthorization required. SNFs—periodic reviews performed for continuing services. ICFs—length of stay beyond 30 days must be approved.
Physicians' Services	One visit per month to same recipient in nursing home unless further substantiation of need. Experimental treatment and cosmetic surgery not covered. Limited coverage of sterilizations, hysterectomies, and abortions. Treatment of mental disorders in physician's office limited to maximum of $500 per calendar year. Preauthorization required for specific services.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Limited to legend drugs and over-the-counter drugs prescribed by licensed physician.

(continued)

Medicaid Jurisdiction and Services

Virgin Islands	
Inpatient Hospital Services	Limited to care in general hospitals operated by the Department of Health except with preauthorization recipient may be transferred to hospital outside Virgin Islands.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFs—preauthroization required. Service limited to persons 21 years or older. ICFS—not provided.
Physicians' Services	Limited services provided by Department of Health except when preauthorization granted.
Outpatient Hospital Services	Limited to services provided by Department of Health except with preauthorization recipient may be transferred to hospital outside Virgin Islands.
Prescription Drugs	Must be provided by Department of Health or pharmacy that has signed providers agreement with Medicaid.
Virginia	
Inpatient Hospital Services	Limited to 14 days with coverage extended up to 21 days for certain admissions certified by Utilization Review Committee.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	Elective surgery, cosmetic surgery, routine physicals, immunizations, and experimental procedures not covered. Preauthorization required for refraction and eyeglasses. Psychiatric services not covered in excess of 26 sessions per year.
Outpatient Hospital Services	Induced abortions covered only when health of mother is substantially endangered.
Prescription Drugs	Limited to legend drugs and also insulin, syringes, needles, and family planning supplies.
Washington	
Inpatient Hospital Services	Admission and length of stay determined by PSRO. No treatment of TB in general hospital; long term psychiatric care in inpatient psychiatric facilities only.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFs—Preauthorization of admission. ICFs—No limitations.
Physicians' Services	Preauthorization required for non–emergency surgery. 2 visits per month in extended care facility; 1 per day in hospital; and 1 per month for all other types of visits. Immunizations covered only if no alternative method of administration is available. Physical exams covered only in specific instances.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Limited to formulary unless preauthorized.
West Virginia	
Inpatient Hospital Services	Limited to 60 days per fiscal year.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	Precertification required on each admission, with recertification for continued stay beyond initial certification in SNFs.
Physician' Services	No limitations.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Limitations on certain non–compensable as well as compensable items.

(continued)

TABLE 4.8 (continued)

Medicaid Jurisdiction and Services	
Wisconsin	
Inpatient Hospital Services	Preauthorization required for selected services.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	SNFs—Concurrent authorization of care and amount of payment required. ICFs—Preauthorization required.
Physicians' Services	Preauthorization required for selected services. Transsexual surgery and artificial insemination are not covered services.
Outpatient Hospital Services	Preauthorization required.
Prescription Drugs	Preauthorization required for amphetamines and other selected drugs.
Wyoming	
Inpatient Hospital Services	No limitations.
Skilled Nursing Facility Services/ Intermediate Care Facility Services	No limitations.
Physicians' Services	No routine vitamin injections. Physical examinations limited to 1 yearly after 3rd year of life. Nursing home visits limited to 1 routine visit per month.
Outpatient Hospital Services	No limitations.
Prescription Drugs	Not provided.

SOURCE State Plans Branch, Bureau of Program Operations, HCFA.
[1] These limitations apply to the categorically needy; they may or may not differ from limitations for the medically needy.

TABLE 4.9

Medical Services Requiring Copayments in the Medicaid Program by Jurisdiction December 1980

Medicaid Jurisdiction	Prescription Drugs	Vision Services	Dental Services	Orthotic and Prosthetic Services	Other Services
Alabama	$.50 per prescription and refills.				
Arkansas	$.50 per prescription excluding those for EPSDT or family planning referrals.				
District of Columbia	$.50 per prescription excluding those for EPSDT or family planning services	$2.00 on eyeglasses not provided as part of an integrated program of medical services			
Georgia	$.50 per prescription excluding those for EPSDT or family planning services.			$.50 on $10 or less; $1.00 on $11–$25; $2.00 on $26–$50; $3.00 on $51 or more.	For ambulance, Podiatry and Psychological services: $.50 on $10 or less; $1.00 on $11–25; $2.00 on $26–$50; $3.00 on $51 or more.
Idaho	$.50 per prescription excluding those for family planning services.				
Kansas	$.50 per each new prescription and refill excluding those for EPSDT or family planning services.				
Maryland	$.50 on all prescription drugs.				
Michigan		$2.00 for each reimbursable visit provided to recipients over age 21.	$3.00 for reimbursable visit provided to recipients over age 21.		
Mississippi	$.50 per prescription and per refill.				
Montana	$.50 per each additional prescription after first two prescriptions.				

(continued)

TABLE 4.9 (continued)
Medical Services Requiring Copayments in the Medicaid Program by Jurisdiction [1]
December 1980

Medicaid Jurisdiction	Prescription Drugs	Vision Services	Dental Services	Orthotic and Prosthetic Services	Other Services
Nevada	Copayment on each prescription as follows: $.50 on $10.00 or less; $1.00 on $10.00–$25.00; $2.00 on $25.01–$50.00; $3.00 on $50.01 or more.				
New Mexico	$.25 per prescription		$2.00 for each dental service visit.		
North Carolina	$.50 per prescription	$2.00 per visit.			Chiropractic services: $.50 per visit. Clinic services: $1.00 per visit.
North Dakota		$3.00 on replacement eyeglasses only if more than 1 pair issued in a calendar year.			
South Carolina	$.50 per prescription.	$1.00 per visit for optometric services.	$1.00 per visit for emergency dental treatment.	Copayment for devices as follows: $.50 on $10.00 or less; $1.00 on $11.00–$25.00; $2.00 on $26.00–$50.00; $3.00 on $51.00 or more.	$1.00 per visit for podiatry services; $.50 per visit for chiropactic services.
South Dakota	$.50 per prescription				
Virginia	$.50 per prescription	$2.00 per pair of eyeglasses. $.50 per repair of eyeglasses.			

SOURCE. State Plans Branch, Bureau of Program Operations, HCFA.
[1] Most jurisdictions do not require copayments for EPSDT services or family planning services.
[2] States not requiring copayments are not included on this table.

TABLE 4.10

Summary of Changes in Coverage in the Medicaid Program by Jurisdiction[1]
January 1980 - June 1980

Jurisdiction	Total Increases	Total Decreases	Inpatient Hospital Services	Outpatient Hospital Services	Physicians' Services	Home Health Services	Podiatrists' Services	Optometrists' Services	Other Practitioners' Services	Dental Services	Physical Therapy	Rehabilitative Services
Alabama[2]	—	8	R	R								
Arkansas	1	3				I					E	E
Colorado	1	—				I						
Connecticut	2	—						I		I		
Idaho	—	1							A			
Kentucky	1	—					A					
Montana	1	—						I				A
New Mexico	1	—										
North Dakota	—	1							E			
Pennsylvania[3]	6	4	L	I				L		I		
Texas	1	—										
Vermont	3	—			I	I						
Wisconsin	—	7										

Jurisdiction	Prosthetic Devices	Eyeglasses	Clinic Services	Emergency Hospital Services	Inpatient Psychiatric For Under 22 Years	Personal Care Services	Christian Science Nurses	Christian Science Sanatoria	Inpatient 65+ TB Institutions	SNF 65+ TB Institutions	ICF 65+ TB Institutions	SNF 65+ Mental Institutions	ICF 65+ Mental Institutions
Alabama[2]				R	R				R				
Arkansas								E					
Colorado													
Connecticut													
Idaho													
Kentucky													
Montana													
New Mexico													
North Dakota													
Pennsylvania[3]	I/L	A	I/L			I							
Texas													
Vermont	I												
Wisconsin						R	R	E	E	E	E	E	

SOURCE: "Report on Selected changes in State Medicaid Programs, January 1, 1980 - June 30, 1980," Bureau of Program Operations, HCFA.
Legend: I = Increase, A = Added, R = Reduced, E = Eliminated, L = Limited.

[1] Changes presented in this table include only those service categories and jurisdictions where change occurred. See pp. 138-141 for a description of all service categories.
[2] Alabama had two reductions and two limitations on inpatient hospital services.
[3] Pennsylvania had a limitation and an increase on both clinic services and prosthetic devices and two increases on outpatient hospital services.

TABLE 4.11

Proportion of Medicaid Recipients Using Specific Services, by Type of Medical Service and Jurisdiction Fiscal Year 1979

Medicaid Jurisdiction	Number of Recipients (thousands)	Proportion of Total Recipients Using Specific Services[1]									
		Inpatient Hospital Services		Skilled Nursing Facility Service	Intermediate Care Facility Services		Physicians' Services	Dental Services	Other Practitioners' Services	Outpatient Hospital Services	Clinic Services
		General Hospital	Mental Hospital		Mentally Retarded	All Other					
All Jurisdictions	21,540.0	17.5%	0.4%	2.8%	0.5%	3.5%	69.7%	20.3%	14.1%	34.8%	7.2%
Alabama	327.9	22.5	(Z)	3.7	—	3.7	71.8	11.5	11.8	31.9	—
Alaska	17.2	12.6	0.9	2.0	1.2	5.0	63.0	20.5	23.1	27.9	2.5
Arkansas	213.4	21.0	0.1	2.8	—	8.0	70.3	16.9	13.4	16.8	7.1
California	3,373,7	15.1	0.1	3.8	—	0.3	72.8	26.4	20.8	41.8	4.8
Colorado	150.6	18.3	0.4	6.1	1.1	6.4	97.9	8.5	—	80.4	—
Connecticut	219.8	16.0	0.9	11.2	(Z)	2.0	67.6	25.1	25.8	50.0	11.0
Delaware	44.6	14.1	0.1	0.5	1.0	2.7	71.3	—	3.9	50.1	11.3
District of Columbia	131.3	17.8	—	0.2	0.5	0.6	60.5	10.7	20.3	49.0	27.4
Florida	435.8	19.8	0.1	3.2	0.2	3.7	71.1	8.8	2.5	39.5	—
Georgia	401.3	25.9	—	3.8	0.4	5.0	70.3	15.3	6.8	41.3	3.6
Hawaii	110.2	12.6	—	2.2	—	1.6	81.4	38.7	8.5	30.0	—
Idaho	41.2	15.8	—	4.2	1.1	5.7	78.2	18.4	4.3	38.4	—
Illinois	1,015.8	18.2	0.5	2.0	—	5.5	77.4	29.5	44.5	31.7	16.8
Indiana	226.4	19.7	(Z)	3.2	0.8	10.1	79.5	17.9	6.3	45.5	1.8
Iowa	169.1	18.8	—	0.3	1.0	12.1	83.0	35.7	23.9	40.7	0.3
Kansas	150.0	21.8	0.7	0.8	2.4	9.7	57.1	25.8	17.6	39.2	4.3
Kentucky	406.8	17.0	0.1	1.7	0.2	3.5	72.4	20.0	5.4	36.3	7.5
Louisiana	388.4	47.4	0.1	0.3	1.0	6.8	67.4	10.8	1.9	1.1	11.3
Maine	156.8	12.6	—	0.4	—	6.1	78.1	24.1	12.6	41.5	1.6
Maryland	293.7	17.1	—	0.3	—	5.0	72.7	22.9	16.8	57.5	—
Massachusetts	1,046.3	19.5	0.3	2.6	0.5	2.8	43.8	18.9	10.6	22.7	5.2
Michigan	897.7	16.5	0.8	3.3	0.6	2.7	81.1	21.9	16.2	43.2	2.4
Minnesota	304.5	19.3	0.3	7.5	3.8	7.6	72.7	36.6	18.9	37.2	2.5
Mississippi	276.3	18.9	—	3.2	0.3	1.3	80.5	14.2	0.2	31.8	(Z)
Missouri	338.1	21.9	0.2	0.3	0.4	4.8	74.0	23.6	13.3	41.5	—
Montana	41.9	20.7	0.4	2.5	0.8	11.7	79.7	30.6	26.4	36.0	—
Nebraska	69.4	23.3	0.3	1.6	1.2	13.4	72.1	25.6	25.8	33.4	24.0
Nevada	21.9	27.0	(Z)	2.9	0.8	9.4	75.6	14.0	11.1	39.2	2.2
New Hampshire	44.0	17.7	(Z)	1.2	0.7	10.7	80.6	22.5	21.4	44.6	6.8
New Jersey	662.7	15.7	0.5	0.5	—	4.7	75.4	30.5	19.8	43.9	4.7
New Mexico	85.7	22.9	—	0.7	0.5	3.5	78.6	21.0	12.8	31.4	4.0
New York	2,364.0	12.9	1.0	4.0	1.0	3.3	51.2	19.5	12.2	52.5	7.9
North Carolina	388.3	20.1	0.3	3.3	0.5	3.3	69.1	21.6	11.1	41.5	10.4
North Dakota	28.8	19.7	0.6	10.9	—	6.1	61.0	32.9	20.7	21.1	0.3
Ohio	725.8	16.5	0.2	3.9	0.5	2.5	68.3	23.8	21.2	52.3	8.4
Oklahoma	257.6	18.7	0.1	(Z)	0.7	9.0	62.3	9.6	—	0.7	—
Oregon	225.5	12.0	0.3	0.8	1.0	5.0	72.2	22.4	5.2	37.8	—
Pennsylvania	1,390.3	17.9	0.7	2.4	1.3	1.5	44.7	16.5	8.4	12.9	23.8
Puerto Rico	1,424.2	4.9	—		•	•	99.5	4.0	—	—	—
Rhode Island	122.9	16.3	0.5	0.5	0.9	5.8	58.8	23.9	17.8	38.4	—
South Carolina	247.8	17.4	0.6	3.6	0.6	3.8	72.5	12.9	7.1	36.9	—
South Dakota	35.1	22.9	—	2.5	2.3	13.3	78.1	13.8	11.0	29.9	2.6
Tennessee	324.6	27.4	0.3	0.9	0.7	6.6	71.8	10.8	—	36.9	11.5
Texas	681.5	23.8	—	1.7	1.6	12.0	82.1	13.3	13.7	29.8	—
Utah	66.5	15.4	0.2	4.5	3.7	8.2	56.3	28.9	14.5	35.4	32.9
Vermont	49.1	17.9	1.0	0.7	1.0	6.0	76.5	23.1	8.1	45.4	(Z)
Virgin Islands	24.1	7.8	—	—	•	•	1.1	6.2	—	71.8	—
Virginia	313.4	17.9	0.2	0.8	0.9	4.8	69.4	16.1	9.3	43.8	18.2
Washington	273.6	19.1	0.1	6.0	0.9	2.2	81.5	33.1	20.7	31.8	28.4
West Virginia	104.4	59.7	3.7	0.2	—	4.3	81.3	17.6	51.8	—	3.5
Wisconsin	420.0	21.4	0.6	9.3	0.5	2.0	79.4	34.3	12.0	33.4	4.0
Wyoming	10.8	19.4	—	4.7	—	5.5	84.9	12.1	7.4	30.8	—

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] The same recipient may appear in more than one column. Therefore proportions across services do not add to 100 percent.

"—" Data not available.

(Z) Indicates a percentage less than 0.05.

• Services not provided.

Skilled nursing facility services provided in public facilities; no Federal financial participation claimed.

TABLE 4.12

Distribution of Medicaid Recipients By Type of Medical Service, Age, and Sex Fiscal Year 1979[1]

Services	Number of Recipients (thousands)	Percentage Distribution by Age and Sex					
		Age[2]				Sex[2]	
		Under 6	6–20	21–64	65+	Male	Female
Total	21,540.0	15.6	31.3	34.3	18.8	34.7	65.3
Inpatient Hospital Services[3]	3,759.1	13.0	19.5	43.4	24.1	30.4	69.6
Skilled Nursing Facility Services	599.1	0.4	1.2	14.0	84.4	27.8	72.2
Intermediate Care Facility Services[4]	760.0	0.5	1.6	16.6	81.3	31.7	68.3
Physicians' Services	15,010.7	17.1	30.6	36.8	15.6	34.0	66.0
Dental Services	4,372.8	8.3	52.9	33.0	5.8	36.4	63.5
Other Practitioners' Services	3,037.9	4.7	32.5	41.2	21.6	29.4	70.6
Outpatient Hospital Services	7,505.7	18.7	31.3	38.1	11.9	34.1	65.9
Clinic Services	1,546.8	21.2	31.1	44.0	3.7	37.2	62.8
Laboratory and Radiological Services	5,346.3	10.7	28.1	42.9	18.3	28.1	71.8
Home Health Services	358.4	14.7	15.7	40.7	29.0	31.4	68.6
Prescribed Drugs	14,189.7	16.2	27.5	37.4	18.9	32.0	68.0
Family Planning Services	1,202.1	0.0	32.4	67.2	0.4	1.8	98.2
Other Care	2,645.4	9.5	24.6	38.0	27.8	4.9	95.1

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] Some states do not report the age and sex of all recipients. Thus the distribution for total jurisdictions will not necessarily be the same by type of medical service as that found on Table 4.6 (Distribution of Recipients by Jurisdiction, Age, and Sex).

[2] Due to rounding and nonreporting, may not sum to 100 percent.

[3] Excludes recipients in mental hospitals.

[4] Excludes recipients in institutions for mentally retarded.

TABLE 4.13

Use of General Hospitals, SNFS, ICFS, Physicians, and Drug Prescriptions Under Medicaid by Jurisdiction Fiscal Year 1979

Medicaid Jurisdiction	General Hospitals			SNFs		ICFs (other than MR)		Physicians	Drug Prescriptions
	Total Discharges	Recipients Discharged	Total Days of Care	Total Recipients	Total Days of Care	Total Recipients	Total Days of Care	Total Visits	Number of Prescriptions
All Jurisdictions	3,490,038	2,156,445	21,527,730	438,082	84,269,384	600,958	147,054,652	66,202,067	145,010,480
Alabama	63,711	46,769	337,453	12,247	2,366,596	12,144	3,044,231	905,155	3,356,899
Alaska	—	—	—	—	—	—	—	—	—
Arkansas	52,594	27,719	201,268	5,870	1,138,863	17,014	4,437,754	1,397,573	2,448,175
California	464,360	337,440	3,150,120	127,420	24,573,960	9,560	1,560,780	11,542,840	20,811,060
Colorado	—	—	—	—	—	—	—	—	—
Connecticut	44,760	35,266	373,683	24,610	4,883,618	4,284	899,835	1,047,559	2,218,234
Delaware	6,929	5,411	54,366	179	18,542	1,184	322,697	132,255	288,185
District of Columbia	59,834	23,395	502,974	325	32,207	851	217,750	1,150,928	775,786
Florida	94,531	53,930	607,431	13,796	1,894,176	16,264	2,365,863	200,132	1,154,192
Georgia	77,378	54,268	526,974	15,353	3,350,488	20,262	5,815,613	807,777	5,961,114
Guam	—	—	—	—	—	—	—	—	—
Hawaii	15,993	11,395	90,201	2,439	386,523	1,732	400,300	458,790	856,246
Idaho	8,473	6,462	36,392	1,744	322,609	2,342	568,462	157,560	355,594
Illinois	248,264	177,008	2,178,321	20,813	3,840,912	56,0381	14,224,553	4,086,106	13,651,173
Indiana	64,948	44,260	358,145	7,172	1,283,103	22,785	6,338,889	555,654	—
Iowa	35,374	23,503	227,582	571	37,868	20,483	5,583,201	1,690,792	1,864,282
Kansas	50,695	32,728	317,174	1,140	112,653	14,626	3,904,884	597,037	1,306,269
Kentucky	71,427	49,688	398,545	6,949	869,674	14,411	3,228,610	2,559,691	2,999,749
Louisiana	113,743	72,591	163,658	1,122	187,272	26,440	6,721,630	1,181,360	4,915,970
Maine	—	—	—	—	—	—	—	—	—
Maryland	48,582	37,630	354,089	—	—	14,587	3,878,028	505,775	2,020,518
Massachusetts	—	—	—	—	—	—	—	—	—
Michigan	202,445	144,429	1,582,367	30,057	6,576,243	24,008	5,350,803	4,999,574	8,816,329
Minnesota	83,686	57,115	594,348	22,872	5,033,126	23,251	5,147,778	1,679,117	3,076,055
Mississippi	43,108	31,162	252,915	8,878	1,843,883	3,652	645,369	746,623	3,242,945
Missouri	75,909	37,478	435,450	1,007	96,958	16,297	4,210,016	1,862,177	3,623,453
Montana	9,990	6,836	57,583	1,042	98,795	4,881	1,148,535	299,777	485,956
Nebraska	13,153	9,368	73,545	1,103	209,201	9,267	2,591,815	392,080	927,300
Nevada	7,378	5,198	43,662	628	36,317	2,060	481,776	111,723	181,726
New Hampshire	8,185	5,471	56,469	—	—	4,706	1,358,066	279,194	476,481
New Jersey	—	—	—	3,389	385,644	30,977	8,494,108	4,425,693	6,081,582
New Mexico	20,490	15,961	86,681	152	19,902	2,974	694,405	238,094	627,190
New York	—	—	—	—	—	—	—	—	—
North Carolina	98,936	76,335	884,652	12,698	1,558,893	12,910	2,590,210	696,681	4,097,482
North Dakota	8,552	5,691	46,326	3,136	672,515	1,769	513,868	154,975	360,097
Ohio	126,519	93,625	807,515	27,952	7,434,927	17,837	5,229,539	1,807,896	6,969,322
Oklahoma	68,291	48,214	456,433	12	2,714	23,207	6,757,732	767,434	1,033,505
Oregon	26,397	20,459	112,746	1,722	233,816	11,191	2,597,561	1,328,700	2,490,558
Pennsylvania	343,554	248,660	2,535,958	33,595	4,604,957	20,674	2,567,935	2,475,415	—
Puerto Rico	75,572	69,975	384,591	@	@	*	*	4,060,002	6,694,434
Rhode Island	13,609	—	1,243,625	566	2,168,375	—	—	306,378	1,079,186
South Carolina	39,985	30,533	230,375	8,857	1,106,610	9,496	1,727,493	—	—
South Dakota	11,363	8,025	42,095	893	175,728	4,658	1,402,859	172,026	103,123
Tennessee	465,551	47,090	362,246	2,943	127,648	21,331	5,495,786	2,276,067	5,985,814
Texas	123,975	84,735	786,530	11,373	1,644,690	81,882	21,496,217	5,493,222	6,485,962
Utah	13,417	10,132	63,310	3,007	385,630	5,471	863,605	66,590	619,123
Vermont	10,973	6,249	57,252	367	32,135	2,439	666,620	283,396	475,826
Virgin Islands	2,012	1,812	11,219	—	—	*	*	1,860	51,816
Virginia	—	—	—	—	—	—	—	—	—
Washington	75,387	55,169	431,450	16,513	4,115,650	6,038	1,459,416	1,070,733	2,481,226
West Virginia	—	—	—	184	8,119	4,475	—	—	—
Wisconsin	—	—	—	—	—	—	—	1,199,656	5,814,881
Wyoming	—	—	—	—	—	—	—	—	*

SOURCE: Health Care Financing Administration, *National Annual Medicaid Statistics*

"—" Data not reported. (Due to nonreporting, the data on this table may not correspond to the data on Table 4.11 or the data reported in Chapter II.)

* Services not provided

@ Skilled nursing facility services provided in public facilities, no federal financial participation claimed.

TABLE 4.14

Early Periodic Screening, Diagnosis, and Treatment Services Provided to Medicaid Children Fiscal Year 1979

Medicaid Jurisidiction	Number of Screenings: Individuals Under Age 21 (thousands)	Number of Screenings: Individuals Under Age 6 (thousands)	Percentage of Individuals Screened With At Least One Condition by Age: Individuals Under Age 21	Percentage of Individuals Screened With At Least One Condition by Age: Individuals Under Age 6
All Reporting Jurisdictions	2,094.21 [1]	1,002.6	51.3% [1]	43.1%
Alabama	43.4	16.3	79.7	63.3
Alaska	4.2	2.3	68.5	65.1
Arkansas	26.7	13.8	42.0	33.8
California	158.8	115.5	67.3	67.8
Colorado	35.0	20.7	32.0	24.3
Connecticut	42.9	28.6	61.1	65.8
Delaware	2.7	1.7	10.7	7.4
District of Columbia	4.5	2.9	41.7	41.0
Florida	73.1	32.0	75.2	65.0
Georgia	57.3	31.5	78.9	64.3
Guam	—	—	—	—
Hawaii	6.6	3.7	41.7	40.7
Idaho	7.9	4.5	35.1	33.9
Illinois	95.4	70.0	9.6	7.8
Indiana	26.9	6.2	—	—
Iowa	19.0	8.0	16.9	16.9
Kansas	13.1	5.5	44.1	39.3
Kentucky	32.3	12.6	67.8	62.8
Louisiana	44.8	22.8	64.8	53.7
Maine	16.0	7.1	6.1	6.1
Maryland	33.1	19.4	36.8	32.3
Massachusetts	167.8	—	57.4	—
Michigan	103.0	43.1	51.6	44.9
Minnesota	17.0	9.5	54.6	57.9
Mississippi	84.7	28.0	89.2	68.8
Missouri	31.5	12.7	36.1	34.1
Montana	1.9	1.1	55.0	54.0
Nebraska	9.2	4.3	21.5	21.1
Nevada	3.7	1.5	87.9	75.3
New Hampshire	6.1	3.8	31.3	22.2
New Jersey	45.4	18.8	34.0	29.0
New Mexico	10.1	4.4	39.0	31.1
New York	143.1	91.8	32.6	29.1
North Carolina	61.6	37.0	30.6	19.0
North Dakota	2.1	0.9	93.7	90.6
Ohio	42.0	14.7	58.3	56.9
Oklahoma	14.0	5.1	45.0	37.4
Oregon	44.3	24.6	76.9	75.3
Pennsylvania	176.0	91.5	60.6	44.9
Puerto Rico	34.1	16.7	73.8	71.4
Rhode Island	14.0	8.0	19.9	18.4
South Carolina	27.9	9.4	75.8	58.6
South Dakota	4.0	2.6	6.6	3.6
Tennessee	55.2	22.2	70.7	44.0
Texas	98.6	38.0	33.8	29.7
Utah	8.5	4.5	40.3	32.3
Vermont	14.9	10.1	5.8	5.4
Virgin Islands	2.7	2.0	58.0	52.1
Virginia	37.5	21.1	25.4	20.2
Washington	40.3	26.7	48.9	48.6
West Virginia	24.0	12.4	44.5	34.7
Wisconsin	23.9	10.6	50.8	44.5
Wyoming	0.8	0.4	33.1	36.3

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, unpublished data.

[1] Numbers and percentages for under age 21 group include those under age 6.

Table 4.15 reports data on sterilizations (by procedure) in all reporting jurisdictions in 1978. About 68,000 procedures were reported in the nation as a whole.[17] Over 20 percent of the total were performed in California. The overwhelming majority of sterilization procedures were provided to females, with tubal ligations the most common method used. Vasectomy was the most common procedure for males.

E. Expenditures

This section presents detailed information on the distribution of total expenditures across and within States and jurisdictions.

Table 4.16 presents payments for Medicaid recipients distinguished by eligibility category and by public assistance status—cash assistance or medical assistance only. Fifty-two percent of the total payments were distributed to cash assistance recipients and 47.6 percent were distributed to medical assistance only recipients. In all eligibility categories except age 65 and over, the majority of payments went to cash assistance recipients.

Medicaid expenditures for recipients by State, rank, and eligibility categories within States are reported in Table 4.17. The largest percent of total expenditures, 37.4 percent went for recipients age 65 and over. This finding can be contrasted with Table 4.5 which shows that persons age 65 and over made up only 15 percent of the total recipients. Blind and other recipient categories each receive a share of total expenditures that is approximately equivalent to their share of recipients. In contrast, AFDC recipients make up 63.6 percent of the total recipients but accounted for only 27.8 percent of the expenditures.

Payments for recipients are also ranked by State. As with the numbers of recipients (Table 4.5), New York and California have the highest payments (although their ranks are reversed). Together, New York and California accounted for 31.4 percent of the total Medicaid expenditures, and six States accounted for over 50 percent of the total expenditures. These six States also rank high in number of recipients. Finally, 16 States account for 75 percent of all payments.

A comparison of the ranking of the Medicaid jurisdictions by number of Medicaid recipients (Table 4.5) and payments for Medicaid recipients (Table 4.17) is contained in Table 4.18. With few exceptions, the rankings for number of and payments for Medicaid recipients is closely associated. The major exception to the general pattern is Puerto Rico which has the third highest recipient population (1.4 million) but expends only $83 million to earn a 39th place ranking among the Medicaid jurisdictions for expenditures. This is a direct result of the Congressionally mandated "cap" on expenditures which has been in place since 1972. Kentucky, Minnesota, Mississippi, Indiana, and Connecticut are the only other Medicaid jurisdictions with relatively large discrepancies between the two rankings.

Table 4.19 indicates average Medicaid payments per recipient by jurisdiction, and the percentage distribution of expenditures within each jurisdiction by recipients' age and sex. Average payment per recipient for all jurisdictions was $950, and individual jurisdiction averages ranged from $1,633 in New York to $58 in Puerto Rico. Twenty-four jurisdictions had average payments of over $1,000.

The distribution of payments among age groupings was not uniform across jurisdictions. There was greater consistency across jurisdictions by sex, with females receiving a larger proportion of payments.

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[17] This total is an underestimate for the nation as a whole because some states (for example, New York) did not report sterilizations and other states did not report for all possible methods. Also, these data show reported sterilizations rather than performed sterilizations.

TABLE 4.15

Sterilizations Provided to Medicaid Recipients by Sex, Type of Procedure, and Jurisdiction, 1978

Medicaid Jurisdiction	Total Sterilizations	Females			Males	
		Tubal Ligation	Hysterec–tomy	Other Procedure	Vasec–tomy	Other Procedure
All Reporting Jurisdictions	68,369	60,363	1,310	3,916	2,756	24
Alabama	1,792	980	737		75	
Alaska	42	38	2		2	
Arkansas	1,776	1,359	416		10	
California	14,286	13,369			917	
Colorado	685	259	8	400	18	
Connecticut	679	667			12	
Delaware	232	232				
District of Columbia	384	384				
Georgia	729	712	15		2	
Hawaii	719	706	1		12	
Idaho	275	222		41	12	
Illinois	4,577	4,524			53	
Indiana	1,021	1,021			0	
Iowa	1,866	834		948	84	
Kansas	1,388	904	6	409	66	3
Kentucky	1,403	1,364	11		28	
Louisiana	313	204		66	7	
Maine	1,536	1,443			93	
Maryland	1,490	1,301	20		169	
Massachusetts	209	205			4	
Michigan	2,325	2,093	8		224	
Minnesota	1,828	1,073		709	35	11
Mississippi	950	949			1	
Missouri	1,156	1,002		124	29	
Montana	286	208	19	40	19	
Nebraska	366	360			6	
Nevada	14	10			4	
New Hampshire	18	17			1	
New Jersey	5,903	5,483		371	49	
New Mexico	9		9			
North Carolina	936	934			2	
North Dakota	60	57		3		
Ohio	2,549	1,761	8	647	133	
Oklahoma	1,020	996			24	
Oregon	881	758			123	
Pennsylvania	4,482	4,439	20		23	
Rhode Island	489	479			10	
South Carolina	782	781			1	
South Dakota	213	209			4	
Tennessee	938	911	15		12	
Texas	2,618	2,344			274	
Utah	171	155	3		13	
Vermont	545	522			23	
Virginia	1,006	1,005	1			
Washington	532	301	9	152	69	1
West Virginia	690	676	2		12	
Wisconsin	2,174	2,059		6	101	8
Wyoming	26	26				

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, unpublished data.

TABLE 4.16

Payments for Medicaid Recipients by Basis of Eligibility and Maintenance Assistance Status, Fiscal Year 1979

Basis of Eligibility	Total Payments (millions)	Distribution of Payments by Maintenance Assistance Status	
		Cash Assistance	Medical Assistance Only
Total	$20,473.5	52.4%	47.6%
Age 65 and over	7,646.9	27.2%	72.8%
Blind	123.2	61.3%	38.7%
Permanently and Totally Disabled	6,103.7	60.1%	39.9%
Dependent Children Under 21	2,864.4	85.0%	15.0%
Adults in Families with Dependent Children	2,835.7	87.0%	13.0%
Other Title XX Recipients	899.5	Not applicable	100.0%

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

Table 4.20 presents the percentage distribution of payments by type of medical service for each jurisdiction. For all reporting States, over 30 percent of medical vendor payments went for inpatient hospital services, approximately 26 percent to ICFs, and 16.5 percent to SNFs. In the District of Columbia, 52.2 percent of medical vendor payments were accounted for by inpatient hospital services, whereas in South Dakota this percentage was only 14.8. Medical vendor payments to skilled nursing facilities ranged from 45.1 percent in Connecticut to less than 0.05 percent in Oklahoma and Maryland. Medical vendor payments to intermediate care facilities ranged from 63.9 percent in South Dakota to 1.3 percent in California. Distribution of medical vendor payments are also included for physicians' services, dental services, other practitioner services, outpatient hospital services, clinic services, laboratory and radiological services, home health services, prescribed drugs, family planning services, and other care.

Total medical payments under Medicaid by form of payment are found on Table 4.21. Medical payments may be made directly to the vendor or through a fiscal agent. Premium or per capita payments may be made into the SSA system for aged or disabled recipients or to health insuring agencies or health maintenance organizations. For the total reporting States as well as for most individual States, the great majority (98 percent) of medical payments are made directly to the vendor or through a fiscal agent rather than as a premium or per capita payment.

Table 4.22 presents comparative data on States' Medicaid programs. States are ranked by their ratio of Medicaid recipients to persons living at or below the poverty level. Average expenditures per Medicaid recipient and average per capita personal income are also reported for each state. For the U.S. as a whole, the ratio of Medicaid recipients to persons at or below the poverty level was 53 percent and the average annual expenditure per Medicaid recipient was $995. It should be noted that persons receiving State-only services are included in this table.

The ratio of Medicaid recipients to persons living at or below the poverty level ranged from 115 percent in Massachusetts to 24 percent in Texas. Average expenditures per Medicaid recipient ranged from $1,689 in New York to $58 in Puerto Rico. There appears to be no clear relationship between these ratios and average expenditures.

Many States choose to cover persons who are not eligible and/or services which are not eligible for Federal matching. These "State-only" expenditures for reporting States are presented in Table 4.23. As the table shows, California and New York together account for 80.6 percent of all such expenditures.

TABLE 4.17

Payments for Medicaid Recipients by Jurisdiction, by Rank of Jurisdiction, and Distribution by Basis of Eligibility Fiscal Year 1979

Medicaid Jurisdiction	Total Payments (millions)	Percent of Total	Cumulative Percent of National Total[1]	Percentage Distribution by Basis of Eligibility[1]				
				Age 65 and Over	Blind	Permanently and Totally Disabled	AFDC	Other Title XX Recipients
All Jurisdictions	$20,473.5	100.0%	100.0%	37.4%	.6%	29.8%	27.8%	4.4%
New York	3,860.6	18.9	18.9	41.4	.4	22.5	25.9	9.7
California	2,557.9	12.5	31.4	27 9	.9	30.0	37.2	4.0
Pennsylvania	1,187.8	5.8	37.2	29.9	.5	28.3	25.0	16.3
Michigan	1,036.4	5.1	42.3	24.4	.3	36.0	37.8	1.4
Illinois	991.8	4.8	47.1	22.0	.3	39.7	37.2	.8
Massachusetts	901.8	4.4	51.5	48.4	1.1	28.5	19.2	2.8
Texas	869.2	4.2	55.7	52.3	.6	31.1	16.0	—
Ohio	669.9	3.3	59.0	34.3	.6	33.0	32.2	—
New Jersey[3]	659.5	3.2	62.2	36.6	.3	23.9	39.2	—
Wisconsin	558.5	2.7	64.9	43.4	.7	34.7	20.9	.4
Minnesota	474.4	2.3	67.2	47.0	.4	31.8	16.4	4.3
Georgia	382.8	1.9	69.1	39.1	.7	38.8	21.4	—
Louisiana	342.3	1.7	70.8	43.4	.6	36.4	19.0	.5
Florida	341.6	1.7	72.5	44.4	.6	30.5	24.5	—
North Carolina	336.7	1.6	74.1	39.7	1.6	34.3	23.4	1.1
Tennessee	322.7	1.6	75.7	41.6	.7	36.8	19.4	1.6
Indiana	314.6	1.5	77.2	40.9	.7	34.9	23.4	—
Virginia	312.0	1.5	78.7	41.8	.7	29.1	28.5	—
Connecticut	296.3	1.4	80.1	41.3	.2	33.4	25.1	(Z)
Washington	290.6	1.4	81.5	32.0	.4	39.1	24.4	4.1
Maryland	258.8	1.3	82.8	36.7	.2	21.4	41.7	(Z)
Oklahoma	251.5	1.2	84.0	44.0	.2	28.6	20.9	6.3
Kentucky	248.8	1.2	85.2	34.6	.8	33.7	31.0	—
Alabama	239.6	1.2	86.4	48.4	.7	26.1	24.9	—
Missouri	238.6	1.2	87.6	38.8	1.1	27.8	28.3	4.0
Iowa	208.3	1.0	88.6	43.5	.7	29.2	25.4	1.1
Arkansas	192.2	.9	89.5	44.8	1.0	34.2	16.6	3.3
South Carolina	191.4	.9	90.4	46.9	.8	29.4	22.0	.9
Kansas	164.4	.8	91.2	34.5	.4	31.8	20.4	12.9
Colorado	162.9	.8	92.0	38.8	.9	31.9	25.0	3.4
Oregon	162.1	.8	92.8	31.0	2.4	30.4	25.8	10.4
Mississippi	148.6	.7	93.5	49.2	.7	23.0	27.0	.1
Rhode Island	139.9	.7	94.2	49.0	.3	34.7	15.6	.4
District of Columbia	139.4	.7	94.9	15.7	.1	34.4	49.7	(Z)
Maine	114.1	.6	95.5	48.8	.2	20.6	30.4	.1
Nebraska	94.3	.5	96.0	45.7	.8	32.6	19.2	1.7
West Virginia	92.9	.5	96.5	32.1	.5	30.0	36.9	.5
Hawaii	86.3	.4	96.9	35.7	.1	21.3	37.2	5.7
Puerto Rico	83.0	.4	97.3	—	.2	4.5	43.7	51.6
Utah	78.6	.4	97.7	32.0	.2	33.5	30.8	3.5
New Hampshire	60.1	.3	98.0	59.7	1.6	20.1	18.5	(Z)
New Mexico	58.4	.3	98.3	26.5	1.3	39.5	30.8	1.8
Montana	53.0	.3	98.6	44.0	.8	33.9	21.4	—
Vermont	52.3	.3	98.9	41.7	.2	33.0	23.6	1.4
South Dakota	49.0	.2	99.1	49.4	.3	33.9	15.8	.6
Idaho	44.9	.2	99.3	38.8	.2	36.7	23.3	1.0
North Dakota	41.8	.2	99.5	58.5	.2	17.9	21.4	2.1
Delaware	38.4	.2	99.7	33.3	.3	33.4	33.0[2]	—
Nevada	32.2	.2	99.9	42.6	1.9	37.9	17.6	—
Alaska	26.7	.1	100.0	27.5	.7	47.6	23.0	1.3
Wyoming	11.3	.1	100.1	51.6	.1	21.4	26.9	—
Virgin Islands	2.6	(Z)	100.1	9.6	.1	3.0	48.4	38.9

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] "Cumulative percent of national total" and "percentage distribution" may not sum to 100% due to rounding.

[2] Includes unknown proportion of Other Title XIX recipients that State was unable to identify separately.

[3] Includes $7.3 million in retroactive payments.

"—" Data not available.

(Z) Percent less than 0.05.

TABLE 4.18

Medicaid Jurisdictions Ranked by Number of Medicaid Recipients And Payments for Medicaid Recipients, Fiscal Year 1979

Medicaid Jurisdiction	Ranking by Number of Medicaid Recipients [1]	Ranking by Payments for Medicaid Recipients [2]
California	1	2
New York	2	1
Puerto Rico	3	39
Pennsylvania	4	3
Massachusetts	5	6
Illinois	6	5
Michigan	7	4
Ohio	8	8
Texas	9	7
New Jersey	10	9
Florida	11	14
Wisconsin	12	10
Kentucky	13	23
Georgia	14	12
Louisiana	15	13
North Carolina	16	15
Missouri	17	25
Alabama	18	24
Tennessee	19	16
Virginia	20	18
Minnesota	21	11
Maryland	22	21
Mississippi	23	32
Washington	24	20
Oklahoma	25	22
South Carolina	26	28
Indiana	27	17
Oregon	28	31
Connecticut	29	19
Arkansas	30	27
Iowa	31	26
Maine	32	35
Colorado	33	30
Kansas	34	29
District of Columbia	35	34
Rhode Island	36	33
Hawaii	37	38
West Virginia	38	37
New Mexico	39	42
Nebraska	40	36
Utah	41	40
Vermont	42	44
Delaware	43	48
New Hampshire	44	41
Montana	45	43
Idaho	46	47
South Dakota	47	45
North Dakota	48	46
Virgin Islands	49	52
Nevada	50	49
Alaska	51	50
Wyoming	52	51

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] From Table 4.5.

[2] From Table 4.17

TABLE 4.19

Average Medicaid Payment per Recipient By Jurisdiction and Distribution of Payments by Age and Sex, Fiscal Year 1979

Medicaid Jurisdiction	Total Payments (millions)	Average Payment Per Recipient	Distribution of Payments by Age and Sex[1]				
			Age			Sex	
			0–20	21–64	65	Male	Female
All Jurisdictions	$20,473.5	$ 950	19.2%	41.4%	38.9%	32.2%	66.6%
Alabama	239.6	731	16.7	34.0	49.2	27.6	72.4
Alaska	26.7	1,554	—	—	—	—	—
Arkansas	192.2	901	17.8	32.4	49.8	33.6	66.4
California	2,557.9	758	21.7	44.6	33.7	27.1	72.9
Colorado	162.9	1,082	—	—	—	—	—
Connecticut	296.3	1,348	11.8	30.4	43.1	29.3	70.7
Delaware	38.4	862	23.0	42.9	34.1	33.1	66.9
District of Columbia	139.4	1,062	26.8	58.1	15.2	35.4	64.6
Florida	341.6	784	17.3	32.7	49.8	28.6	71.0
Georgia	382.8	954	14.8	35.0	50.2	32.1	67.9
Guam	—	—	—	—	—	—	—
Hawaii	86.3	783	21.0	43.3	35.7	37.8	62.2
Idaho	44.9	1,089	21.3	37.1	41.5	34.9	65.1
Illinois	991.8	976	22.5	49.8	27.6	35.3	64.7
Indiana	314.6	1,390	14.2	39.2	46.6	31.0	69.0
Iowa	208.3	1,232	19.8	36.9	37.7	33.6	66.4
Kansas	164.4	1,096	23.5	42.2	34.2	38.3	61.7
Kentucky	248.8	612	22.7	39.6	37.7	33.6	66.4
Louisiana	342.3	881	19.7	36.1	44.2	33.9	66.1
Maine	114.1	728	13.3	37.8	48.8	—	—
Maryland	258.8	881	23.6	37.3	39.1	29.7	70.3
Massachusetts	901.8	862	—	—	—	—	—
Michigan	1,036.4	1,155	23.9	49.9	26.2	36.4	63.6
Minnesota	474.4	1,558	13.5	34.6	51.9	36.4	63.6
Mississippi	148.6	538	16.5	33.2	50.3	30.7	69.3
Missouri	238.6	706	16.2	40.1	43.7	30.3	69.7
Montana	53.0	1,265	17.4	36.2	46.1	36.8	62.8
Nebraska	94.3	1,360	15.6	36.8	47.6	34.4	65.1
Nevada	32.2	1,471	16.0	39.2	44.8	35.1	64.9
New Hampshire	60.1	1,367	11.3	28.9	59.7	28.7	71.3
New Jersey[2]	659.5	995	24.4	36.6	39.0	33.7	66.3
New Mexico	58.4	682	21.8	45.3	32.8	32.6	65.6
New York	3,860.6	1,633	—	—	—	—	—
North Carolina	336.7	867	17.7	40.4	41.9	34.0	66.0
North Dakota	41.8	1,449	12.2	29.3	58.5	34.6	65.4
Ohio	669.9	923	18.0	43.2	38.7	31.9	68.1
Oklahoma	251.5	916	24.4	30.6	45.0	36.3	63.7
Oregon	162.1	719	23.4	44.9	31.7	36.6	63.7
Pennsylvania	1,187.8	854	15.7	52.8	31.6	38.6	61.4
Puerto Rico	83.0	58	45.9	54.1	0.0	36.7	63.3
Rhode Island	139.9	1,138	14.4	34.9	50.7	31.3	68.7
South Carolina	191.4	773	15.0	35.8	49.2	22.7	77.3
South Dakota	49.0	1,396	12.6	33.1	54.3	36.8	63.2
Tennessee	322.7	994	16.6	37.4	46.1	32.4	67.6
Texas	869.2	1,275	14.3	32.7	53.1	31.6	68.4
Utah	78.6	1,183	25.5	41.4	33.1	37.6	62.4
Vermont	52.3	1,066	19.7	36.9	43.3	34.9	65.1
Virgin Islands	2.6	106	38.8	51.7	9.6	32.6	67.4
Virginia	312.0	995	—	—	—	—	—
Washington	290.6	1,062	13.8	47.4	38.8	37.0	63.0
West Virginia	92.9	890	22.6	32.6	14.2	7.5	19.6
Wisconsin	558.5	1,330	18.6	36.0	45.4	36.5	63.5
Wyoming	11.3	1,047	—	—	—	—	—

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*

[1] Percentages may not sum to 100% due to unknowns and rounding.

[2] Includes $7.3 million in retroactive payments.

"—" Data not available.

TABLE 4.20

Medicaid Medical Vendor Payments by Type of Medical Service and Jurisdiction, Fiscal Year 1979

Medicaid Jurisdiction	Total Payments (millions)	Percentage Distribution by Type of Medicial Service					
		Inpatient Hospital Services		Skilled Nursing Facility Services	Intermediate Care Facility Services in Institutions		Physicians' Services
		General Hospital	Mental Hospital		For Mentally Retarded	All Other Institutions	
All Reporting Jurisdictions	$20,473.5	27.6%	3.8%	16.5%	7.4%	18.4%	8.0%
Alabama	239.6	25.9	(Z)	19.5	—	24.5	10.8
Alaska	26.7	18.2	(Z)	8.8	21.9	29.4	7.0
Arkansas	192.2	18.0	0.1	12.8	—	42.5	8.6
California	2,557.9	36.9	1.5	22.6	—	1.3	14.0
Colorado	162.9	15.5	3.0	14.0	23.3	23.3	7.3
Connecticut	296.3	19.5	6.0	45.1	0.1	5.4	5.7
Delaware	38.4	23.5	2.5	1.2	14.6	29.3	10.1
District of Columbia	139.4	52.5	—	1.0	9.5	5.4	10.0
Florida	341.6	36.1	1.6	14.5	2.4	17.6	9.4
Georgia	382.8	26.0	—	14.3	7.2	24.3	9.2
Guam	—	—	—	—	*	*	—
Hawaii	86.3	20.4	—	22.6	—	18.0	16.0
Idaho	44.9	16.3	—	16.9	15.6	24.5	11.0
Illinois	991.8	33.0	8.0	7.9	—	21.6	9.7
Indiana	314.6	19.5	0.7	12.2	6.7	38.5	7.6
Iowa	208.3	18.6	—	0.7	15.9	40.7	9.0
Kansas	164.4	20.7	2.9	1.3	17.7	36.2	6.9
Kentucky	248.8	25.9	0.4	10.8	6.0	25.8	12.0
Louisiana	342.3	21.2	0.4	1.1	15.7	35.7	9.4
Maine	114.1	22.8	—	2.6	—	46.5	10.0
Maryland	258.8	38.9	—	(Z)	—	34.8	6.3
Massachusetts	901.8	36.5	2.8	13.6	11.8	13.7	5.4
Michigan	1,036.4	33.1	4.0	15.6	10.6	11.8	11.6
Minnesota	474.4	16.0	1.1	29.0	15.2	19.3	6.2
Mississippi	148.6	24.7	—	26.1	4.6	9.3	11.7
Missouri	238.6	31.5	2.4	0.8	7.5	31.3	8.9
Montana	53.0	19.8	0.7	3.8	7.2	43.0	10.5
Nebraska	94.3	17.5	2.2	5.9	10.6	41.9	6.0
Nevada	32.2	24.6	0.3	3.3	8.2	41.5	10.6
New Hampshire	60.1	17.3	(Z)	2.3	4.8	56.1	6.6
New Jersey1	659.5	23.2	7.0	1.8	—	40.1	8.3
New Mexico	58.4	30.4	—	1.3	8.6	24.0	16.7
New York	3,860.6	24.7	8.4	25.0	6.2	12.2	3.1
North Carolina	336.7	28.5	3.0	14.2	9.7	17.1	8.4
North Dakota	41.8	20.9	4.8	34.5	—	19.8	6.9
Ohio	669.9	26.6	3.2	22.5	9.3	12.6	7.6
Oklahoma	251.5	22.4	1.4	(Z)	12.8	44.2	7.4
Oregon	162.1	17.4	2.8	3.6	20.4	28.2	11.1
Pennsylvania	1,187.8	35.3	8.4	15.7	15.0	7.7	4.4
Puerto Rico	83.0	40.3	—	@	*	*	23.7
Rhode Island	139.9	33.3	4.0	2.7	12.5	31.0	3.5
South Carolina	191.4	21.6	4.1	17.1	8.0	24.0	8.7
South Dakota	49.0	14.8	—	6.0	20.7	43.2	7.4
Tennessee	322.7	21.0	1.0	1.3	12.7	35.7	8.8
Texas	869.2	16.7	—	4.3	15.2	41.0	9.2
Utah	78.6	19.8	1.9	12.7	19.5	25.1	5.8
Vermont	52.3	18.4	7.3	1.9	14.0	31.5	11.8
Virgin Islands	2.6	43.7	—	—	*	*	2.0
Virginia	312.0	23.5	2.6	2.5	12.8	31.8	8.6
Washington	290.6	21.8	0.5	24.3	12.3	11.7	10.0
West Virginia	92.9	46.5	0.2	0.1	—	25.4	9.7
Wisconsin	558.5	18.0	1.8	44.1	3.4	11.1	4.1
Wyoming	11.3	20.0	—	16.0	—	48.8	10.1

(continued)

TABLE 4.20 (continued)
Medicaid Medical Vendor Payments by Type of Medical Service And Jurisdiction, Fiscal Year 1979

Medicaid Jurisdiction	Percentage Distribution by Type of Medical Service								
	Dental Services	Other Practitioners' Services	Outpatient Hospital Services	Clinic Services	Laboratory & Radiological Services	Home Health Services	Prescribed Drugs	Family Planning Services	Other
All Reporting Jurisdictions	2.1%	0.8%	4.1%	1.3%	0.9%	1.3%	5.9%	0.5%	1.4%
Alabama	1.5	0.7	3.9	—	2.8	0.8	8.9	0.4	0.2
Alaska	1.9	0.9	2.9	0.4	(Z)	0.1	—	0.1	2.8
Arkansas	2.0	0.5	1.3	1.0	1.7	0.1	9.9	0.1	1.4
California	3.2	2.1	5.4	0.6	3.1	0.1	6.1	1.9	1.2
Colorado	1.0	—	4.2	—	1.2	0.4	6.0	0.2	0.7
Connecticut	1.4	1.0	5.2	2.6	0.5	1.2	4.8	(Z)	1.5
Delaware	—	0.3	5.9	0.4	1.8	0.5	4.8	1.8	3.4
District of Columbia	0.8	0.9	8.0	3.3	0.4	1.7	3.5	0.5	2.5
Florida	1.0	0.3	5.5	—	0.1	0.1	9.7	0.2	1.4
Georgia	1.9	0.5	3.8	1.1	0.1	0.3	9.7	0.5	2.1
Guam	—	—	—	—	—	—	—	—	—
Hawaii	7.5	1.0	3.8	—	2.6	0.4	5.9	0.4	1.3
Idaho	1.7	0.3	3.4	—	1.6	0.3	5.2	0.4	2.8
Illinois	2.6	1.1	3.2	3.1	0.7	0.2	8.0	—	1.0
Indiana	1.2	0.6	3.1	0.2	0.2	0.5	7.1	0.3	1.7
Iowa	3.0	1.0	2.7	(Z)	0.1	0.2	6.4	0.5	1.1
Kansas	1.9	0.7	2.6	1.2	0.3	0.2	6.7	0.3	0.4
Kentucky	2.7	0.4	4.2	3.5	0.1	1.2	5.5	0.7	1.0
Louisiana	1.9	0.1	0.1	1.2	0.2	0.2	11.5	0.3	1.1
Maine	1.6	0.8	5.1	0.1	(Z)	0.8	7.3	0.7	1.8
Maryland	1.7	0.8	10.2	—	0.3	0.2	5.4	1.1	0.3
Massachusetts	2.0	0.7	5.5	1.3	0.4	1.1	3.6	0.3	1.2
Michigan	1.9	0.8	2.1	0.1	1.1	0.2	5.7	0.6	0.8
Minnesota	2.3	0.8	2.4	0.1	(Z)	0.5	4.4	0.4	2.3
Mississippi	2.1	(Z)	3.2	(Z)	0.2	0.3	14.7	0.7	2.3
Missouri	3.7	1.1	3.0	—	0.1	0.2	8.8	0.4	0.1
Montana	3.1	2.0	2.1	—	0.2	0.4	4.7	0.3	2.3
Nebraska	1.7	0.9	1.5	1.2	1.9	0.5	7.4	0.3	0.7
Nevada	1.5	0.7	2.8	0.1	0.2	0.5	4.3	—	1.4
New Hampshire	1.0	0.9	2.8	0.8	0.2	1.0	5.1	0.1	0.8
New Jersey	3.2	0.4	6.2	0.8	0.3	1.0	5.6	0.4	1.6
New Mexico	3.1	1.3	4.1	0.2	0.4	0.5	7.6	0.2	1.5
New York	1.3	0.3	5.4	2.6	0.4	5.2	2.6	0.3	2.4
North Carolina	3.4	0.4	3.3	1.8	0.5	0.2	8.7	0.5	0.5
North Dakota	3.3	1.0	1.6	(Z)	0.2	0.1	6.2	0.2	0.4
Ohio	2.0	1.3	6.2	0.5	0.2	0.1	6.9	0.1	1.0
Oklahoma	1.1	—	0.1	—	0.3	(Z)	3.0	(Z)	7.1
Oregon	2.6	0.9	3.7	—	1.8	0.1	4.9	0.8	1.7
Pennsylvania	1.6	0.4	0.9	3.6	0.6	0.1	1.7	0.1	0.4
Puerto Rico	1.0	—	—	—	5.0	—	27.1	—	3.0
Rhode Island	1.9	0.3	4.0	—	0.2	0.2	5.0	0.2	1.0
South Carolina	1.6	0.3	3.4	—	1.1	0.5	7.5	0.7	1.5
South Dakota	0.9	0.4	1.8	0.1	0.4	(Z)	3.5	0.1	0.6
Tennessee	1.2	—	4.0	1.9	0.1	0.3	11.1	0.2	0.7
Texas	2.1	0.4	1.9	—	1.7	0.1	6.7	0.3	0.4
Utah	2.1	1.1	2.7	2.5	0.2	0.2	4.8	0.2	1.4
Vermont	1.7	0.2	3.3	(Z)	1.0	1.6	5.8	0.7	0.6
Virgin Islands	1.0	—	34.7	—	0.2	0.1	13.4	0.8	4.2
Virginia	1.4	0.5	5.8	0.7	1.3	0.4	6.4	0.3	1.4
Washington	4.2	1.4	2.5	2.7	0.5	0.4	5.2	0.6	1.8
West Virginia	2.0	3.6	—	0.2	0.3	0.2	10.3	0.1	1.3
Wisconsin	2.8	1.3	3.9	0.8	0.1	0.5	5.7	0.5	1.8
Wyoming	1.3	0.6	2.6	—	0.2	0.1	*	0.3	(Z)

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, *National Annual Medicaid Statistics.*
"—" Data not available.
(Z) Percentage less than 0.05.
* Services not provided.
@ Skilled nursing facility services provided in public facilities; no federal financial participation claimed.
1 Includes $7.3 million in retroactive payments.

TABLE 4.21

Total Medical Payments Under Medicaid by Form of Payment Fiscal Year 1979

Medicaid Jurisdiction[1]	Total Payments[2] (millions)	Directly to Vendor or Through Fiscal Agent (millions)	Premium or Per Capita Payments			
			SSA System for			
			Aged Recipients (millions)	Disabled Recipients (millions)	Health Insuring Agency (millions)	Health Maintenance Organization (millions)
All Reporting Jurisdictions	$21,072.4	$20,330.5	$ 237.7	$ 57.5	$312.3	$131.1
Alabama	250.0	241.1	7.3	1.6		
Alaska	20.4	20.4				
Arkansas	205.3	198.4	6.7	.2		
California	2,582.1	2,464.5	35.7	22.0		59.8
Colorado	170.2	164.0	2.8	.4		3.0
Connecticut	298.8	297.7	.8	.2	.1	
Delaware	39.8	39.4	.4	.1		
District of Columbia	139.5	138.1	.8	.2		.3
Florida	363.2	350.5	9.5	3.2		
Georgia	396.2	384.3	10.8	1.2		
Hawaii	85.5	83.3	.8	.2		1.1
Idaho	46.9	46.3	.5	.2		
Illinois	1,061.4	1,055.3	2.8	2.1		1.2
Indiana	320.9	317.3	2.5	1.0		
Iowa	227.1	224.6	2.2	.8		
Kansas	171.3	164.8	5.4	1.1		
Kentucky	267.1	260.4	6.7			
Louisiana	353.0	353.0				
Maine	116.1	114.4	1.7			
Maryland	272.1	256.1	3.0	.9		12.2
Massachusetts	915.2	905.0	9.1			1.1
Michigan	1,091.1	1,042.3	4.5	2.7		41.6
Minnesota	477.0	475.0	1.2	.6		.2
Mississippi	203.7	195.0	8.2	.4		
Missouri	245.6	239.1	5.0	1.5		
Montana	54.3	53.4	.7	.2		
Nebraska	102.8	102.1	.4	.4		
Nevada	32.7	32.3	.4	.1		
New Hampshire	60.7	60.4	.2	.1		
New Jersey	671.1	662.6	6.3	1.1		1.1
New Mexico	61.6	59.8	1.2	.6		
New York	3,890.9	3,861.9	23.5		5.5	
North Carolina	375.5	367.4	6.7	1.3		
North Dakota	42.4	41.2	.4	.1	.8	
Ohio	677.0	667.5	8.7	.1		.7
Oklahoma	267.2	262.8	4.0	.4		
Oregon	165.1	162.3				2.8
Pennsylvania	1,203.9	1,191.9	6.4	3.5		12.2
Puerto Rico	83.0	83.0				
Rhode Island	141.0	139.9	.6	.5		.1
South Carolina	186.1	180.0	4.5	1.6		
South Dakota	49.7	49.1	.5	.1		
Tennessee	332.0	322.7	9.3			
Texas	936.2	605.2	22.1	2.9	305.9	
Utah	81.4	78.9	.2	.1		2.2
Vermont	53.1	49.4	.6			
Virgin Islands	2.7	2.6	.1	(Z)		
Virginia	320.5	314.0	3.3	3.2		
Washington	269.8	265.4	2.1	.7		1.6
West Virginia	93.9	91.4	2.5			
Wisconsin	587.2	582.3	4.9			(Z)
Wyoming	11.3	11.3				

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, Unpublished Data.

[1] No data available for Guam and Northern Mananas

[2] Data in Table 4.20 are generated from monthly data whereas payment data in other tables come from annual reports. Year-end corrections in monthly estimates are responsible for the discrepancies between these two data sets

(Z) Percentage less than 0.5.

TABLE 4.22

Medicaid Recipients Relative to Persons Below the Poverty Level, Average Expenditures Per Medicaid Recipient, And Per Capita Personal Income Ranked by Jurisdiction[1], Fiscal Year 1979

Medicaid Jurisdiction	Ratio of Medicaid Recipients to Persons Living Below the Poverty Level[2]	Average Payment Per Medicaid Recipient[3]	Per Capita Personal Income[4]
Average All Jurisdictions	53%	$ 995	$8,773
Massachusetts	115	796	8,893
Hawaii	94	784	9,223
California	93	774	10,047
Rhode Island	92	1,040	8,510
New York	79	1,689	9,104
District of Columbia	72	1,062	10,570
Maine	71	728	7,039
Pennsylvania	69	854	8,558
Puerto Rico	68	58	—
Oregon	67	719	8,938
Maryland	66	871	9,331
New Jersey	64	995	9,747
Michigan	58	1,155	9,403
Wisconsin	58	1,396	8,484
Alaska	57	1,554	11,219
Illinois	55	976	9,799
Connecticut	53	1,348	10,129
Delaware	52	862	9,327
Washington	51	1,062	9,565
Minnesota	47	1,558	8,865
Kentucky	46	612	7,390
Vermont	44	1,075	7,329
Kansas	43	1,096	9,233
Louisiana	42	881	7,583
Oklahoma	42	976	8,509
Colorado	40	1,082	9,122
Ohio	40	923	8,715
Alabama	39	731	6,962
New Hampshire	39	1,367	8,351
Iowa	37	1,232	8,772
South Carolina	37	773	7,057
Utah	37	1,183	7,197
Virginia	35	995	8,587
Arkansas	34	901	6,933
Missouri	34	706	8,251
Tennessee	33	994	7,343
Montana	32	1,265	7,684
Wyoming	32	1,047	9,922
Georgia	31	954	7,630
Idaho	30	1,089	7,571
New Mexico	30	682	7,560
North Carolina	30	867	7,385
Indiana	29	1,390	8,570
Mississippi	26	226	6,178
Nevada	26	1,471	10,521
West Virginia	26	890	7,372
Florida	24	784	8,546
Nebraska	24	1,360	8,684
North Dakota	24	1,449	8,231
South Dakota	24	1,396	7,455
Texas	24	1,275	8,788

SOURCES: Medicaid Data - Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA; Income Data - Survey of Current Business, U.S. Department of Commerce, Vol. 60, No. 8, August 1980.

[1] Guam and the Virgin Islands are not included in the table due to problems with data on the Medicaid program, population, and poverty.

[2] Numerator data were calculated from data submitted by the States to HCFA. Data from seven state were estimated from 1978 data and deta from Pennsylvania were adjusted due to a sampling problem. The numerator includes an estimate of the total number of persons receiving Medicaid services in each state regardless of whether Federal monies were involved. Denominator data were developed from U.S. Bureau of Census data provided by the Office of the Deputy Assistant Secretary for Planning and Evaluation/ Health, DHHS. The denominator was adjusted to include an estimate of those receiving Mediceid who were not poor.

[3] This average was calculated by dividing total expenditures, exclusive of non-Medicaid recipient payments, by the total number of Mediceid recipients es reported to HCFA.

[4] Per capita personal income is for CY 1979.

TABLE 4.23

Medicaid State-Only Expenditures
Fiscal Year 1979

Jurisdiction [1]	Total Expenditures (millions)
All Jurisdictions	$ 944.9
Alaska	1.9
California	500.5
Colorado	.1
Georgia	.2
Hawaii	15.0
Illinois	77.5
Louisiana	.7
Maine	.3
Maryland	55.5
Massachusetts	2.8
Michigan	4.8
Montana	3.8
New York	261.1
North Carolina	1.9
North Dakota	.1
Oregon	12.1
South Dakota	1.2
Utah	.4
West Virginia	.4
Wisconsin	4.6

SOURCE: Medicaid Program Data Branch, Office of Research, Demonstrations, and Statistics, HCFA, unpublished data.

[1] Some Medicaid jurisdictions that are known to have State-only expenditures, such as Pennsylvania, have chosen not to report these non-Federal expenditures.

F. Financing

Payments to providers of health care to the Medicaid eligible population come from several sources including:

- the Federal government through the Medicaid Federal Medical Assistance Percentages formula;
- the Federal government through the Medicare program;
- State governments;
- local governments (in some cases);
- third parties who are otherwise liable for care provided to Medicaid eligibles; and
- the Medicaid eligibles themselves.

This section presents data on these sources of funds, except for private third parties and expenditures contributed by the Medicaid eligibles themselves. No State collects data on these expenditures.

1. Federal/State Financing

The Federal share of State medical vendor payments is determined by a statutory formula based on State per capita income:

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2 \times 45\%}$$

Federal share = 100% minus the State share

By design, the formula provides a higher percentage of Federal matching funds to States with low *per capita* incomes (up to a statutory maximum of 83 percent); and a lower percentage of Federal matching funds to States with high *per capita* incomes (down to a minimum of 50 percent).

Table 4.24 presents the Federal Medicaid Assistance Percentages now in effect. No State receives the maximum Federal match (Mississippi receives the highest at 77.55 percent) while 17 States receive the minimum. These percentages apply to medical vendor payments only. Federal matching rates for other expenditures are as follows:

- Family Planning Services are matched at 90 percent;
- Administrative costs are matched at 50 percent;
- Development of automated claims processing and management information systems are matched at 90 percent and the operation of such systems is matched at 75 percent;
- Costs of skilled nursing facility inspectors are matched at 100 percent;
- Costs of professional medical personnel used to administer the program are matched at 75 percent; and
- State Medicaid fraud and abuse units located organizationally outside of the single State agency are matched at 90 percent.

The share of total expenditures for medical assistance borne by the States will vary with the extent to which States provide medical assistance to State-only categories of eligibles, and offer services which do not qualify for Federal financial participation.

Table 4.24 also presents the total medical vendor payments subject to Federal financial participation (FFP) and the Federal, State and local share of such payments. These expenditure data may differ from expenditure data in other tables. Total payments computable for Federal funding represent only those payments for which FFP is allowed and exclude other payments (such as Medicare SMI premiums paid on behalf of the medically needy) for which FFP is not allowed. The adjusted Federal share is the official accounting of payments to providers and reflects such accounting adjustments as changes in payments to cost reimbursed providers following year-end audits.

2. Local Funding Formulas

Under the law, the non-Federal share of medical vendor payments may be provided out of State or local revenues. A State plan must provide, however, that at least 40 percent of the non-Federal share be borne directly by the State. The State plan must also guarantee that lack of local funds will not result in lower amounts, duration, scope, or quality of care provided to Medicaid eligibles. Nine States provide for local funding of the nonFederal share of Medicaid vendor payments. Table 4.24 presents the total expenditures financed by these local funding sources. Table 4.25 presents the formulas used by these States for local funding.

TABLE 4.24

Medicaid Vendor Payments by Jurisdiction
Fiscal Year 1979

Medicaid Jurisdiction	Total Payment Computable for Federal Funding (millions) [1]	Percent Federal Share	Adjusted Federal Share (millions)	State Share (millions)	Local Share (millions)
All Reporting Jurisdictions	$20,736.0		$11,385.5	$8,449.5	$812.6
Alabama	237.3	71.32%	174.1	64.9	0
Alaska	28.5	50.00	15.3	13.6	0
Arkansas	200.5	72.87	146.2	55.9	0
California	2,618.6	50.00	1,294.2	1,306.2	0
Colorado	163.7	53.16	88.0	73.6	0
Connecticut	296.5	50.00	146.7	147.8	0
Delaware	39.0	50.00	21.0	19.2	0
District of Columbia	142.0	50.00	70.0	70.4	.3
Florida	364.6	58.94	203.9	158.1	0
Georgia	400.5	66.76	257.4	136.5	0
Guam	2.2	50.00	.9	0	1.1
Hawaii	83.9	50.00	41.8	41.7	0
Idaho	46.4	65.70	30.4	16.9	0
Illinois	957.4	50.00	471.7	477.4	0
Indiana	318.1	57.86	181.1	137.0	0
Iowa	205.5	56.57	106.0	75.5	22.7
Kansas	171.3	53.52	89.1	81.4	0
Kentucky	258.7	68.07	179.1	78.0	0
Louisiana	344.6	68.82	247.1	101.9	0
Maine	125.1	69.53	87.0	37.7	0
Maryland	338.1	50.00	170.3	168.4	0
Massachusetts	963.8	51.75	490.7	465.7	0
Michigan	1,070.6	50.00	541.6	532.1	0
Minnesota	488.5	55.64	267.4	197.5	20.4
Mississippi	203.7	77.55	161.9	44.4	0
Missouri	235.7	60.36	148.7	92.4	0
Montana	54.4	64.28	33.2	21.1	0
Nebraska	95.3	57.62	53.7	28.7	15.6
Nevada	32.8	50.00	16.1	16.3	0
New Hampshire	61.5	61.11	38.4	22.8	0
New Jersey	684.3	50.00	343.5	340.8	0
New Mexico	60.8	69.03	43.9	16.9	0
New York	3,630.4	50.00	1,757.4	1,116.5	693.8
North Carolina	347.6	67.64	241.4	88.1	23.4
North Dakota	42.6	61.44	21.5	18.7	2.3
Ohio	681.7	55.10	382.9	303.3	0
Oklahoma	261.9	63.64	173.8	90.4	0
Oregon	166.4	55.66	96.6	69.6	1.0
Pennsylvania	1,141.4	55.14	623.2	487.9	23.5
Puerto Rico	60.2	50.00	28.3	24.5	7.4
Rhode Island	134.9	57.81	79.7	57.9	0
South Carolina	196.2	70.97	135.9	54.9	0
South Dakota	49.9	68.78	31.7	17.7	0
Tennessee	322.7	68.88	222.3	100.4	0
Texas	937.1	58.35	566.8	367.8	0
Utah	74.7	68.07	57.3	22.9	.2
Vermont	53.6	68.40	36.7	17.1	0
Virgin Islands	1.5	50.00	.8	(Z)	.8
Virginia	302.4	56.54	181.0	129.6	0
Washington	302.0	50.00	156.1	145.4	0
West Virginia	94.1	67.35	65.7	28.1	0
Wisconsin	629.7	57.95	360.0	260.4	0
Wyoming	11.3	50.00	6.0	5.2	0

SOURCE: *Expenditures for Public Assistance Programs Fiscal Year 1979,* Office of Research and Statistics, SSA, DHHS.

[1] "Total Payment Computable for Federal Funding" represents only those payments for which FFP is allowed. Thus these numbers differ from "Total Payments" found in other tables.

(Z) Less than .05.

TABLE 4.25

Local Funding Formulas for Medicaid Vendor Payments by Jurisdiction[1]
December 1980

Medicaid	Formula[2]
Florida	Counties contribute funding in two areas: (1) When inpatient hospital care days exceed 12 per admission, counties pay 35 percent of non–Federal share for cost of care beyond 12 days; (2) When nursing home vendor payments exceed $170 per month, counties pay 35 percent of the non–Federal share of that amount above $170, but not more than $55 per patient per month.
Minnesota	All non–Federal share split 39.32 percent State and 4.44 percent local, excluding costs for State facilities for the mentally retarded for which no local funding is utilized.
Nebraska	Counties pay 16 percent of total Medicaid costs.
New Hampshire	There is local funding for services for the aged and disabled: (1) For nursing home costs for the aged and disabled, legally liable units (i.e., cities, towns, or counties) pay 50 percent of the non–Federal share; (2) For all other services for the aged and disabled, legally liable units pay $6 per month per old age recipient and $23 per month per APTD recipient.
New Jersey	Counties pay 25 percent of total cost for EPSDT outreach programs and 10 percent of total cost for family planning. For these services, local funds constitute all non–Federal funds.
New York	Counties pay 50 percent of non–Federal share.
North Carolina	Counties pay 4.83 percent of State share except 11.27 percent for skilled nursing and intermediate care facilities (excluding intermediate care facilities for the mentally retarded).
North Dakota	Counties pay 15 percent of State share.
Pennsylvania	Counties pay 10 percent of non–Federal share.

SOURCE: State Plans Branch, Bureau of Operations, HCFA, DHHS.
[1] Only those states with local funding formulas are inluded in the table.
[2] The following changes in local funding formulas have occured since 1979:
California's local funding was derived from property taxes with affluent counties assessed more than poorer ones, but with the passage of Proposition 13, local funding is no longer used
Minnesota's non-Federal share was formerly split 40.266 percent State and 4.474 percent local.
Nebraska's counties initially paid 20 percent of total Medicaid costs. This was subsequently reduced to 18 percent. Legislation has been introduced to further decrease the county share.
Nevada and South Dakota no longer use local funding.

3. State Buy-In with Medicare

If an individual eligible for Medicaid under a State plan is also eligible for Medicare Part B, a State can enroll such individual in Part B, by paying the Part B premiums. Under this buy-in arrangement, some of the costs of providing care that would otherwise be borne by the State are thus borne by the Federal government. (For a more detailed discussion, see Chapter I, Section C.1.)

Table 4.26 presents the number of individuals enrolled in Medicare Part B under a buy-in arrangement, the number of such individuals receiving services, and the total payments made under Medicare's SMI program on behalf of Medicaid beneficiaries. All but five jurisdictions buy into the Medicare SMI program.

G. Administrative Practices

1. Methods of Reimbursement

Medicaid regulations specify several criteria and methods for reimbursing providers. Table 4.27 displays the method of reimbursement by State for inpatient hospital services, outpatient hospital services, and physicians' services.

States are required by law to reimburse for inpatient hospital services on the same basis as Medicare—reasonable costs—unless they have approval from the Secretary of the Department of Health and Human Services (DHHS) to use an alternative method of reimbursement. An alternative method will be approved only if the method:

TABLE 4.26

Medicaid State Buy-Ins With Medicare by Jurisdiction, Number of Persons Served, and Reimbursement, Fiscal Year 1979

Medicaid Jurisdiction	Number of State Buy-ins Enrolled (thousands)	Number of Persons with Reimbursed Services [1] (thousands)	Distribution of Persons with Reimbursed Services		Total Amount of Reimbursement (millions)	Distribution of Reimbursement	
			Aged [2]	Disabled [3]		Aged	Disabled
All Reporting Jurisdictions	3,330.3	2,437.2	84.9%	15.1%	$1,507.0	77.3%	22.7%
Alabama	130.6	85.6	89.9	10.1	34.1	82.6	17.4
Alaska [4]	0.0	.1	70.5	29.5	.1	28.6	71.4
Arkansas	81.7	53.9	89.7	10.3	21.8	86.5	13.5
California	640.4	531.6	80.4	19.6	446.5	75.0	25.0
Colorado	35.8	28.4	90.0	10.0	14.1	84.6	15.4
Connecticut	11.3	8.8	82.8	17.2	5.9	74.0	26.0
Delaware	4.7	3.3	79.8	20.2	1.9	61.9	38.1
District of Columbia	15.7	11.3	83.3	16.7	12.2	66.1	33.9
Florida	147.1	109.7	89.1	10.9	87.4	83.5	16.5
Georgia	138.5	93.5	86.6	13.4	42.8	77.3	22.7
Guam	.7	.2	96.9	3.1	.1	48.3	51.7
Hawaii	12.2	10.1	82.9	17.1	8.0	71.9	28.1
Idaho	7.8	5.9	84.8	15.2	2.1	80.0	20.0
Illinois	53.3	41.1	88.7	11.3	26.2	74.8	25.2
Indiana	42.0	32.3	84.4	15.6	14.4	74.0	26.0
Iowa	39.6	27.6	87.6	12.4	11.3	82.0	18.0
Kansas	33.9	25.5	84.1	15.9	12.6	78.2	21.8
Kentucky	72.4	42.8	89.9	10.1	15.5	81.8	18.2
Louisiana [4]	0.0	1.2	88.4	11.6	.8	79.5	20.5
Maine	18.5	12.9	79.2	10.8	5.3	75.7	24.3
Maryland	49.3	36.7	86.2	13.8	25.9	78.4	21.6
Massachusetts	105.9	75.9	87.0	13.0	42.3	89.2	10.8
Michigan	79.1	57.2	76.5	23.5	36.3	69.8	30.2
Minnesota	19.5	14.3	83.8	16.2	7.0	73.0	27.0
Mississippi	90.8	65.3	91.7	8.3	26.9	83.7	16.3
Missouri	69.1	48.4	89.0	11.0	21.8	84.4	15.6
Montana	9.8	6.9	84.9	15.1	3.2	78.0	22.0
Nebraska	8.6	6.1	76.6	23.4	2.7	66.8	33.2
Nevada	5.5	4.9	87.4	12.6	4.3	81.3	18.7
New Hampshire	3.0	2.2	81.2	18.8	1.2	69.1	30.9
New Jersey	80.5	61.5	83.0	17.0	45.9	76.9	23.1
New Mexico	19.6	11.8	88.1	11.9	6.3	80.3	19.7
New York	249.7	176.8	82.8	17.2	119.0	76.3	23.7
North Carolina	94.5	72.2	86.2	13.8	38.2	72.5	27.5
North Dakota	4.4	3.2	86.4	13.6	1.4	77.3	22.7
Ohio	102.2	80.9	79.8	20.2	42.5	72.4	27.6
Oklahoma	47.7	32.8	91.5	8.5	14.0	88.4	11.6
Oregon [4]	0.0	1.0	75.8	24.2	.7	73.5	26.5
Pennsylvania	108.0	67.3	84.6	15.4	42.7	72.6	27.4
Puerto Rico [4]	0.0	1.0	83.3	16.7	.7	63.6	36.4
Rhode Island	11.2	8.3	84.1	15.9	5.1	77.6	22.4
South Carolina	72.4	48.7	86.6	13.4	18.2	76.3	23.7
South Dakota	6.7	3.8	88.8	11.2	1.4	85.8	14.2
Tennessee	100.3	61.1	86.6	13.4	25.9	77.2	22.8
Texas	280.0	203.5	90.9	9.1	109.6	83.3	16.7
Utah	8.7	6.7	81.9	18.1	3.4	75.3	24.7
Vermont	6.9	4.9	79.3	20.7	2.2	73.1	26.9
Virgin Islands	1.0	.2	94.8	5.2	.1	95.7	4.3
Virginia	75.6	54.3	82.8	17.2	31.4	68.5	31.5
Washington	53.6	41.6	82.9	17.1	20.0	76.6	23.4
West Virginia	26.7	15.9	86.8	13.2	6.3	80.8	19.3
Wisconsin	54.1	35.9	79.5	20.5	17.0	71.7	28.3
Wyoming [4]	0.0	.1	81.1	18.9	.1	81.6	18.4

SOURCE: Office of Statistics and Data Management, Office of Research, Demonstrations, and Statistics, HCFA, unpublished data.

[1] Based on Part B bills (physicians, outpatient services, home health agency services, and other suppliers of services) paid in 1979 and processed in central office files through March 1980. The recipient and reimbursement count for each state is atributed to a person's state of residence at the time the bill was processed and is not necessarily the state which bought-in for that person.

[2] Includes aged 65 and over with end-stage renal disease.

[3] Includes disabled with end-stage renal disease as well as persons under 65 entitled solely on basis of end-stage renal disease.

[4] No buy-in agreement, therefore the number of state buy-ins enrolled at any time is zero. It should be noted, however, that recipient and reimbursement counts are attributed to the person's state of residence at the time the bill was processed. The state of residence is not necessarily the state which bought-in for that person.

TABLE 4.27

Medicaid Reimbursement Methods by Type of Service and Jurisdiction
December 1980

Medicaid Jurisdiction	Inpatient Hospital Services	Outpatient Hospital Services	Physicians' Services
Alabama	Same as Medicare.	Same as Medicare.	Same as Medicare.
Alaska	Same as Medicare.	Same as Medicare.	Usual, customary, and reasonable charges up to maximum established by department.
Arkansas	Same as Medicare.	Lesser of amount billed or maximum charge; allowed not to exceed Medicare.	Same as Medicare.
California	Approved alternative plan. Lesser of each hospital's customary charges; allowable costs in accordance with applicable Medicare standards and principles of reimbursement; or all inclusive rate per dischrage.	Maximum allowable fee schedule.	Maximum allowable schedule.
Colorado	Approved alternative plan, 'The Prospectively Determined Hospital Rate System.' Reimbursement based on prospective, rather than historic expenses, not to exceed Medicare.	Reimbursed on an interium basis, based on billings; retrospective adjustment is made based on periodic cost audit.	Reasonable charges according to unit values.
Connecticut	Same as Medicare.	Fee per visit or service.	Customary and reasonable charges.
Delaware	Same as Medicare.	Same as Medicare.	Lesser of usual and customary cnarges or maximum fee.
District of Columbia	Same as Medicare.	Fixed fee basis.	Same as Medicare.
Florida	Same as Medicare.	Customary and prevailing charges which are reasonable or a per visit rate.	Lesser of usual and customary charges or maximum allowable fee schedule established by State agency.
Georgia	Same as Medicare.	Same as Medicare.	Reasonable charges.
Guam	Same as Medicare.	1970 Hawaii Relative Value Scale.	1970 Hawaii Relative Value Scale.
Hawaii	Same as Medicare.	Lesser of reasonable cost or customary charges.	Usual and customary fees, but not exceeding the 75th percentile of range of customary charges prevailing in the State.
Idaho	Approved alternative plan. Prospectively determined rates established by forecast of economic indicators with adjustment at years end for actual experience.	Customary and reasonable charges.	1977 Medicare rates.
Illinois	Approved alternative plan. Rate based on budget packages submitted by hospitals.	Reasonable cost determined by state agency.	Customary and reasonable charges not to exceed upper limit.
Indiana	Same as Medicare.	Usual and customary charges with fixed maximum rate.	Same as Medicare.
Iowa	Same as Medicare.	Same as Medicare.	Same as Medicare.

(continued)

TABLE 4.27 (continued)

Medicaid Reimbursement Methods by Type of Service and Jurisdiction
December 1980

Medicaid Jurisdiction	Inpatient Hospital Services	Outpatient Hospital Services	Physicians' Services
Kansas	Same as Medicare.	Same as Medicare.	Customary charges with fixed maximum.
Kentucky	Same as Medicare.	Same as Medicare.	Usual customary, reasonable and prevailing charges.
Louisiana	Same as Medicare.	Based on cost or charges, whichever is lower.	Same as Medicare.
Maine	Same as Medicare.	Same as Medicare.	Fee schedule.
Maryland	Approved alternative plan. Lesser of reasonable cost or customary charges.	Reasonable cost.	Fixed fee schedules.
Massachusetts	Approved alternative plan. Reasonable cost in accordance with principles adopted by Massachusetts Rate Commission.	Percentage of charges or fee per visit.	Fixed negotiated fee schedule.
Michigan	Approved alternate plan. Lesser of customary charge to the general public or the reasonable cost or reasonable cost plus an incentive payment.	Reasonable cost.	Reasonable charge as determined by Department of Social Service.
Minnesota	Same as Medicare.	Reasonable charges.	Usual and customary charges.
Mississippi	Same as Medicare.	Seventy-five percent of usual and customary charges not to exceed Medicare cost.	Statewide uniform fee schedule.
Missouri	Same as Medicare.	Reasonable charge as deter mined by the Division of Family Services.	Reasonable charge as determined by the Division of Family Services.
Montana	Same as Medicare.	Lesser of reasonable cost or customary charges not to exceed Medicare cost.	Lowest of actual charge for service, or median charge by individual practitioner during the calendar year, or reasonable charge under Medicare, or the 75th per-centile of the range of weighted customary charges for the locality.
Nebraska	Same as Medicare.	Maximum payments set by the Department of Public Welfare.	Maximum payments set by the Department of Public Welfare.
Nevada	Same as Medicare.	Lesser of billed charges or fixed fee per unit fee per unit value.	Lesser of billed charges or fixed fee per unit value.
New Hampshire	Same as Medicare.	Same as Medicare.	Fee schedule.
New Jersey	Approved alternative plan. SHARE system designed to conform with Blue Cross contract principles.	Rates established by Commission of Human Services.	Established fee structure.
New Mexico	Same as Medicare.	Customary and reasonable charges not exceeding Title XVIII payments.	Same as Medicare.

(continued)

TABLE 4.27 (continued)

Medicaid Reimbursement Methods by Type of Service and Jurisdiction
December 1980

Medicaid Jurisdiction	Inpatient Hospital Services	Outpatient Hospital Services	Physicians' Services
New York	Approved alternative plan. Rate schedules based on hospital financial and statistical reports.	Reasonable costs.	Fee schedules.
North Carolina	Same as Medicare.	Ninety percent of allowable cost.	Usual, customary and reasonable charges not to exceed Medicare charges.
North Dakota	Same as Medicare.	Same as Medicare.	Lowest of actual charge, median charge, or reasonable charge.
Northern Marianas	Lesser of billed charges or actual costs not to exceed Medicare rates.	Rates no higher than charged by Government Medical System.	Rates no higher than are charged by Government Medical System.
Ohio	Same as Medicare.	Customary and reasonable charges.	Customary and reasonable charges up to maximum limit.
Oklahoma	Same as Medicare.	Negotiated rates.	Same as Medicare.
Oregon	Same as Medicare.	Same as Medicare.	Same as Medicare.
Pennsylvania	Approved alternative plan. Reasonable current allowable cost.	State Agency Fee Schedule.	State Agency Fee Schedule.
Puerto Rico	Same as Medicare	Reasonable cost.	Actual cost for clinic physicians; standard fee regulated by Secretary of Health for private practitioners.
Rhode Island	Approved alternative plan. Prospective reimbursement program using MAXICAP to establish outside limitation on hospital operating expenditures.	Fee schedule.	Negotiated fee schedule.
South Carolina	Same as Medicare.	Same as Medicare.	Reasonable charges as determined through use of Medicare Charge Profile Data.
South Dakota	Same as Medicare.	Same as Medicare.	Lower of billed charges or prevailing charges as established for the State, except for deductibles and coinsurance charges under Medicare, which will be paid as indicated by the Medicare carrier.
Tennessee	Same as Medicare.	Same as Medicare.	Payment up to 90% of usual and customary charge or up to 90% of the 75th percentile under Medicare.
Texas	Same as Medicare.	Same as Medicare.	Reasonable charge not to exceed provider's customary charge, prevailing charges in the locality, or actual charge.
Utah	Same as Medicare.	Same as Medicare.	Lowest of 90% of actual charge; median of charge for given service during previous year; Medicare charge; or, if the median charge or Medicare charge have not been updated in the previous year, current fiscal year comparisons are made by computation.

(continued)

TABLE 4.27 (continued)

Medicaid Reimbursement Methods by Type of Service and Jurisdiction
December 1980

Medicaid Jurisdiction	Inpatient Hospital Services	Outpatient Hospital Services	Physicians' Services
Vermont	Same as Medicare.	Same as Medicare.	Lowest of actual charge, reasonable charge, or the amount calculated by applying designated conversion factors to prevailing charges established under Medicare for Calendar Year 1976.
Virgin Islands	Same as Medicare.	Fee Schedule.	Medicare reasonable charges within Virgin Islands, usual customary of prevailing charges rendered on referral basis or outside Virgin Islands.
Virginia	Same as Medicare.	90% of allowable costs.	Lowest of fee schedules, charges or Medicare allowable charges.
Washington	Same as Medicare.	Professional fee. Facility – Same as Medicare.	Usual and customary charge up to maximum.
West Virginia	Same as Medicare.	Fee schedule.	Fee schedule.
Wisconsin	Same as Medicare.	Same as Medicare.	Lowest of actual charge, median of physician's charge for service, reasonable charge, or physician's December 23, 1974 rate for service.
Wyoming	Same as Medicare.	Customary and reasonable charges not exceeding Medicare payments.	Lowest of actual charges or Medicare allowable.

SOURCE: State Plans Branch. Bureau of Programs Operations, HCFA.

(1) provides incentives for efficiency and economy;
(2) provides for payment rates that are no higher than the amounts that would be determined using Medicare principles of cost reimbursement;
(3) assures adequate participation of hospitals in the State's Medicaid program, and the availability of hospital services of high quality to recipients;
(4) affords individual providers an opportunity to submit evidence and obtain prompt administrative review of payment rates set for them in certain instances; and
(5) provides for documentation that is adequate for evaluation experience under the approved methods and standards.

As of December 31, 1980, 10 States and one territory (Northern Marianas) had received approval from DHHS to use an alternative method for reimbursement of inpatient hospital services.

For all other services, States are not required to use the Medicare method of payment; however, Medicaid reimbursement may not exceed the amounts paid under Medicare. Seventeen States have elected to use the Medicare method of payment for outpatient hospital services and 10 States use the Medicare methods of payment for physicians' services. For skilled nursing facility services and intermediate care facility services, States have been subject to the requirement that payment systems be reasonably related to cost. Use of a cost-related payment system for long-term care institutional services has been required by law since July 1, 1976, but became fully operational in different States at different times after that date. This cost-related requirement was altered by the Omnibus Reconciliation Act of 1980.

Federal regulations for determining payments for prescription drugs, known as the maximum allowable cost (MAC) system, went into effect in August 1976. The purpose of the regulations is to place an upper limit on payments made under Medicaid for selected prescribed drugs, available from multiple sources. The exception to this regulation is that a physician may specify in writing that a higher cost drug is required. Payment for all drugs prescribed under Medicaid must be made on the basis of MAC, or acquisition cost as estimated by the State, plus a dispensing fee, or the provider's usual and customary charge to the public, whichever is lower.

2. State Administration, Training, and Provider Certification Overall

Administration of the State Medicaid program is vested in single State agencies. Within each agency, State plans must designate a medical assistance unit responsible for developing, analyzing, and evaluating the Medicaid program. The law further requires the States to establish medical care advisory committees to advise the Medicaid agency director about health and medical services. This committee must include board certified physicians and other representatives of the health professions, members of consumer groups, and the director of either the State public welfare or the public health department (whichever department does not run the Medicaid agency).

Medicaid regulations establish certain standards concerning personnel administration in State Medicaid programs. First, each State must employ a merit system of personnel administration. Second, the State plan must provide for a training program for agency personnel. This program must include inservice training for new staff, be related to job duties, and be consistent with program objectives. Finally, the State plan must provide for the training and effective use of subprofessional staff and unpaid volunteers. Federal financial participation is available to States for administrative and training costs. Table 4.28 provides data on State payments for administration and training that are computable for Federal financial participation.

Table 4.28 also shows the total Federal funds obligated to States to finance a survey of each SNF and ICF. These surveys are conducted to determine whether the SNF and ICF facilities continue to meet the prescribed standards required for Medicaid participation.

3. Institutional Provider Participation

Table 4.29 reports the number of the following types of institutional providers, by State: general hospitals, psychiatric hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, independent labs, rural health clinics, and end-stage renal disease facilities. The providers counted are certified to participate in the Medicaid program, whether or not they actually participate. Of the 6,288 general hospitals participating, two States, California and Texas, accounted for over 1,000 of the facilities, or 16.4 percent. The two States with the largest numbers of psychiatric hospitals were New York (40) and California (34). Skilled nursing facilities in California, Pennsylvania, and New York accounted for approximately 30 percent of the total number participating in Medicaid.

There were 10,487 intermediate care facilities certified to participate in the Medicaid program in December 1979. These facilities were spread rather uniformly with the exceptions of Ohio (815), Texas (899), and Illinois (702) which had very large numbers of intermediate care facilities, while the District of Columbia had seven and Guam, Puerto Rico and Virgin Islands had none.

There were totals of 3,416 independent laboratories and 2,811 home health agencies. Close to 33 percent of the rural health clinics that are certified to participate in Medicaid programs are found in three States: North Carolina, Tennessee, and California. There were 963 end-stage renal disease facilities, with six States accounting for 46.2 percent of the total number.

TABLE 4.28

Medicaid Costs for State Administration and Training, and State Certification

Medicaid Jurisdiction	State Administration and Training— Total Payment Computable For Federal Funding Fiscal year 1979 (millions)	State Certification— Total Funds Obligated Fiscal Year 1980 (millions)
All Reporting Jurisdictions	$1,058.0	$37.1
Alabama	8.8	0.5
Alaska	1.4	0.1
Arkansas	7.1	.7
California	156.2	2.8
Colorado	8.4	.6
Connecticut	12.8	.6
Delaware	1.9	.1
District of Columbia	7.9	.1
Florida	23.7	1.1
Georgia	20.9	1.2
Guam[1]	.1	
Hawaii	3.7	.1
Idaho	3.3	.1
Illinois	40.4	1.4
Indiana	1.0	1.2
Iowa	8.5	1.0
Kansas	8.7	.5
Kentucky	14.4	.5
Louisiana	14.3	.5
Maine	4.8	.6
Maryland	15.8	.2
Massachusetts	19.4	1.8
Michigan	84.7	1.9
Minnesota	19.8	1.6
Mississippi	10.1	.4
Missouri	9.9	.7
Montana	3.9	.1
Nebraska	8.0	.5
Nevada	3.2	.1
New Hampshire	3.8	.2
New Jersey	32.0	.5
New Mexico	4.3	.2
New York	188.9	.9[2]
North Carolina	21.9	.8
North Dakota	3.3	.1
Northern Marianas[1, 3]		
Ohio	36.6	1.2
Oklahoma	18.6	.6
Oregon	14.9	.5
Pennsylvania	45.5	1.6
Puerto Rico[4]	4.6	
Rhode Island	4.4	.3
South Carolina	10.5	.4
South Dakota	2.0	.4
Tennessee	11.3	.7
Texas	68.5	4.5
Utah	4.7	.3
Vermont	2.6	.2
Virgin Islands[4]	.4	
Virginia	13.7	.1
Washington	19.5	.5
West Virginia	5.8	.2
Wisconsin	16.5	1.8
Wyoming	.7	.1

SOURCES: Stata and Local Administration and Training Data from "Expanditures for Public Assistanca Programs, Fiscal Yaar 1979", Offica of Policy, Offica of Research and Statistics, SSA, DHHS; Stata Cartification Data from Haalth Standards Quality Buraau, HCFA, DHHS.

1 Doas not participata in Stata Certification Program.
2 Doas not includa fourth quarter data.
3 Did not participata in Madicaid program in 1979.
4 Participatas in Medicara Certification Program only.

TABLE 4.29

Number of Medicaid-Certified Institutional Providers By Type of Provider, and Jurisdiction [1] December 1979

Medicaid Jurisdiction	General Hospitals	Psychiatric Hospitals	Skilled Nursing Facilities	ICFs	Home Health Agencies	Independent Labs	Rural Health Clinics	End-Stage Renal Disease
All Reporting Jurisdictions	6,288	394	7,262	10,487	2,811	3,416	353	963
Alabama	133	3	177	158	85	39	12	17
Alaska	24	1	11	13	1	4	6	1
Arkansas	95	2	82	131	87	22	0	13
California	533	34	1,121	315	135	860	29	127
Colorado	89	5	131	159	39	50	4	11
Connecticut	44	8	214	69	84	73	0	11
Delaware	9	2	11	23	7	12	0	3
District of Columbia	13	2	4	7	4	11	0	9
Florida	222	20	267	268	133	132	13	56
Georgia	169	10	226	274	58	47	13	28
Guam	1	0	1	0	1	3	0	1
Hawaii	24	1	24	16	9	26	1	6
Idaho	48	0	55	56	14	8	7	2
Illinois	253	19	372	702	128	187	1	55
Indiana	123	12	123	409	45	39	1	9
Iowa	152	4	27	422	103	16	8	9
Kansas	178	8	48	359	58	27	4	4
Kentucky	108	4	91	172	52	37	10	15
Louisiana	139	6	12	207	77	47	0	23
Maine	53	2	17	141	18	2	12	4
Maryland	63	7	11	161	29	68	0	18
Massachusetts	153	12	217	396	143	119	2	18
Michigan	221	14	325	377	64	158	4	35
Minessota	186	7	306	390	83	24	0	14
Mississippi	117	0	123	119	132	22	13	15
Missouri	171	8	70	198	47	91	0	18
Montana	66	0	80	90	16	8	0	4
Nebraska	123	4	34	214	17	10	1	7
Nevada	22	2	23	27	6	20	2	3
New Hampshire	29	2	23	67	41	5	3	2
New Jersey	118	11	201	220	45	98	0	22
New Mexico	40	0	4	38	42	17	17	2
New York	318	40	514	241	121	208	9	80
North Carolina	146	12	141	157	11	18	54	19
North Dakota	55	1	56	33	11	13	0	4
Ohio	208	19	365	815	109	122	7	29
Oklahoma	130	5	2	353	61	51	0	15
Oregon	78	4	48	151	31	39	3	4
Pennsylvania	248	29	489	193	116	163	10	59
Puerto Rico	54	1	0	0	27	37	0	10
Rhode Island	16	2	68	106	13	30	3	4
South Carolina	75	4	83	111	20	16	3	11
South Dakota	64	0	57	115	27	6	16	5
Tennessee	156	9	51	217	143	39	35	16
Texas	502	18	219	899	83	215	3	68
Utah	41	1	42	83	9	16	7	6
Vermont	16	2	23	46	18	3	7	1
Virgin Islands	2	0	0	0	1	1	0	2
Virginia	110	12	49	150	45	32	2	28
Washington	108	5	234	40	31	77	10	8
West Virginia	66	3	34	75	29	20	13	9
Wisconsin	148	16	339	479	87	23	8	23
Wyoming	28	1	17	25	15	5	0	0

SOURCE State Plans Branch, Bureau of Program Operations, HCFA, "State Agency Profiles."

[1] Providers may be certified for the Medicaid program but may not actually participate

4. Eligibility Determination Level

States are allowed several options for administering mandatory coverage of SSI recipients:

- States electing to extend Medicaid to all SSI recipients can enter into an agreement with the Social Security Administration under Section 1634 of the Act for determinations of Medicaid eligibility. Social Security then provides States with eligibility information for the purpose of issuing Medicaid identification cards and maintaining State eligibility files for processing Medicaid claims;
- States electing to extend Medicaid eligibility to recipients of SSI can maintain eligibility determinations on a State level; or
- States electing the 209(b) option (where recipients of cash assistance under SSI are not automatically eligible for Medicaid) can require cash assistance recipients to make a separate application for Medicaid.

The option chosen by each State is listed in Table 4.30. Twenty-seven States elected to have Federal determination; seven States elected to extend Medicaid to all recipients of SSI but to maintain eligibility determination on a State level; and there were sixteen 209(b) States.

5. Medicaid Management Information System (MMIS)

The Social Security Amendments of 1972 authorized 90 percent Federal matching to States for the costs of design, development, and installation of mechanized claims processing and information retrieval systems, and 75 percent for the costs of operating such systems.

The MMIS is a general conceptual design that can be tailored by State Medicaid agencies to their own particular needs so long as the system meets Federally required minimum performance standards. The conceptual design includes six subsystems: recipient, provider, claims processing, reference file, surveillance and utilization review, and management and administration reporting. The first four subsystems work together with the overall objective of processing and paying each eligible provider for every valid claim. The other two subsystems consolidate and organize data necessary for managing and controlling the Medicaid program.

Table 4.30 summarizes current State progress in developing and implementing MMIS-type systems. Twenty-six States, New York City and 3 upstate counties of New York have been approved for 75 percent Federal financial participation (FFP) for operation of a mechanized claims processing and information retrieval system. Eleven States and 4 upstate regions of New York anticipate operation and approval of 75 percent FFP during Federal fiscal year 1981. Nine States and 5 regions of New York are currently in the planning, development, or installation phase. Seven jurisdictions with Medicaid programs have no active Federal MMIS plan. American Samoa and Arizona do not have Medicaid programs. Current statutory authority for MMIS development is P.L. 92-603, Section 235 and Title 42 CFR 433 Subpart C, September 29, 1979.

6. Review for Fraud and Abuse

Under the law, a State plan must specify criteria and methods for identifying suspected fraudulent use of the Medicaid program, methods for investigating cases, and procedures for referring suspected fraud to law enforcement officials. The Medicare-Medicaid Anti-Fraud and Abuse Amendments further authorize 90 percent Federal Financial Participation for the establishment and operation of Medicaid Fraud Control Units in the States.

These units must be a single identifiable entity located outside the Medicaid agency (for example, in the Office of the State Attorney General). Fraud Control Units are responsible for investigating and prosecuting (or referring for prosecution) violations of State Medicaid laws, reviewing complaints alleging abuse or neglect of patients, recovering overpayments, and recipient fraud. Staff of such units must include attorneys, auditors and investigators. To receive Federal Financial Participation at the 90 percent rate, the unit must be certified by the U.S. Department of Health and Human Services. At the end of 1979, 29 units with 803 investigators, auditors and attorneys were certified.

Table 4.31 presents the results of State efforts to combat fraud and abuse during fiscal year 1980. Integrity reviews are initial reviews resulting from suspected fraud or abuse, which often result in the recovery of overpayments. Full scale investigations are expanded reviews typically involving questions of the medical necessity of care and requiring reviews by medical consultants, peer review committees, or Professional Standards Review Organizations (PSROs). It is interesting to note that 64.4 percent of all overpayment collection resulting from integrity reviews were generated by three States (Connecticut, Illinois, and New York). Two States (Illinois and New York) accounted for 85.6 percent of all collections resulting from full scale investigations.

TABLE 4.30

Medicaid Eligibility Determination and Status of State Medicaid Management Information Systems by Jurisdiction, December 1980

Medicaid Jurisdiction	Eligibility Determination[1]			Medicaid Management Information Systems			
	Section 1634	State Determination	209(b) State	Certified	Certification Anticipated FY 81	Certification Implementation Plan	No MMIS
Alabama	X			X			
Alaska		X				X	
Arkansas	X			X			
California	X			X			
Colorado		X		X			
Connecticut			X			X	
Delaware	X						X
District of Columbia	X					X	
Florida	X			X			
Georgia	X			X			
Guam							X
Hawaii			X	X			
Idaho		X		X			
Illinois			X			X	
Indiana			X	X			
Iowa	X			X			
Kansas		X		X			
Kentucky	X					X	
Louisiana	X			X			
Maine	X				X		
Maryland	X					X	
Massachusetts	X					X	
Michigan		X		X			
Minnesota			X		X		
Mississippi			X		X		
Missouri			X		X		
Montana	X				X		
Nebraska			X		X		
Nevada		X				X	
New Hampshire			X	X			
New Jersey	X			X			
New Mexico	X			X			
New York			X				
New York City				X			
3 Upstate Counties				X			
4 Upstate Regions					X		
5 Regions						X	
North Carolina			X	X			
North Dakota			X	X			
Northern Marianas							X
Ohio			X	X			
Oklahoma			X	X			
Oregon		X				X	
Pennsylvania	X				X		
Puerto Rico							X
Rhode Island	X						X
South Carolina	X				X		
South Dakota	X				X		
Tennessee	X			X			
Texas	X			X			
Utah			X	X			
Vermont	X			X			
Virgin Islands							X
Virginia			X	X			
Washington	X			X			
West Virginia	X				X		
Wisconsin	X			X			
Wyoming	X						X

SOURCES Eligibility Determination - State Plans Branch, Bureau of Program Operations, HCFA, Medicaid Management Information Systems - Office of Methods and Systems, Bureau of Program Operations, HCFA

[1] Eligibility determination for the territories is based on separate regulations and is found in 42 CFR 436. The Medicaid agency may not require a separate application for Medicaid from an individual if the individual receives cash assistance under a State plan for OAA, AFDC, AB, APTD, or AABD.

TABLE 4.31

Medicaid Provider Fraud and Abuse Activity by Jurisdiction
Fiscal Year 1980

Medicaid Jurisdiction	Integrity Reviews			Full Scale Investigations		
	Number Completed FY 80	Overpayments FY 80	Number Pending, End FY 80	Number Completed FY 80	Overpayments FY 80	Number Pending, End FY 80
All Reporting Jurisdictions	21,498	$ 8,224,751	7,621	3,130	$32,800,857	2,679
Alabama	924	5,397	82	79	22,015	17
Alaska	0	0	0	0	0	0
Arkansas	96	14,195	48	15	8,264	6
California	925	0	736	211	1,056,434	276
Colorado	62	53,234	6	11	26,316	0
Connecticut	1,667	1,554,210	0	22	133,446	2
Delaware	0	0	0	16	8,508	1
District of Columbia	0	0	2	2	0	2
Florida	36	290	94	45	135,766	30
Georgia	22	0	22	42	253,655	0
Hawaii	15	0	85	6	0	23
Idaho	97	953	3	19	71,706	3
Illinois	2,529	1,498,834	744	242	4,770,725	428
Indiana	1,258	0	253	17	48,816	2
Iowa	76	7,113	5	1	0	0
Kansas	1,456	0	0	206	172,964	176
Kentucky	338	47,089	14	8	707	4
Louisiana	128	18,802	57	64	24,092	31
Maine	53	14,651	13	15	53,153	8
Maryland	180	101,915	74	76	0	70
Massachusetts	1,707	575,479	2,447	400	150,689	0
Michigan	233	149,535	0	19	299,112	51
Minnesota	748	29,306	192	5	0	15
Mississippi	341	32,077	0	26	8,362	3
Missouri	258	0	234	59	35,147	7
Montana	38	0	16	3	34	2
Nebraska	29	0	2	5	0	11
Nevada	113	21,380	0	18	835	3
New Hampshire	186	30,956	7	47	15,411	58
New Jersey	1,977	1,520	0	479	477,473	709
New Mexico	46	0	59	25	83,553	18
New York	769	2,292,806	399	411	23,021,166	179
North Carolina	135	0	47	73	63,803	87
North Dakota	51	5,069	7	1	1,252	0
Ohio	2,411	198,279	922	96	1,019,762	124
Oklahoma	264	657	61	4	0	5
Oregon	289	257,605	89	99	65,240	16
Pennsylvania	654	5,823	248	43	70,428	88
Puerto Rico	4	0	0	5	0	0
Rhode Island	169	0	0	1	195,570	0
South Carolina	34	10,004	0	1	0	0
South Dakota	0	0	0	2	6,159	0
Tennessee	213	94,941	43	19	40,309	6
Texas	57	11,242	271	71	0	118
Utah	317	378,824	131	0	0	11
Vermont	95	0	4	11	1,072	5
Virginia	70	0	25	20	96,944	47
Washington	158	60,338	15	90	361,969	32
West Virginia	0	0	0	0	0	0
Wisconsin	270	752,227	164	0	0	5
Wyoming	0	0	0	0	0	0

SOURCE Office of Program Validation, Bureau of quality control, HCFA.

H. Medicaid Data System

The majority of information presented in this report concerning Medicaid comes from a compilation of the annual and monthly Medicaid reports submitted by the State Title XIX Medicaid agencies on the HCFA-2082 and HCFA-120 reports. The States obtain this information from their own Medicaid claims processing and payment operations. As a result, the data reported for a given fiscal year represent the bills paid during that year or month, not the services used during the year.

The major claims processing and payment system used in the States is the Medicaid Management Information Systems (MMIS). The General System Design (GSD) for these systems, completed and distributed in 1972, allowed for considerable variation in certain characteristics of the MMIS's. This flexibility was and is congruent with the programmatic diversity existing across State programs. However, creating standardized reports out of systems employing non-standard coding, processing, and file structures is obviously problematic. Compounding these difficulties is the programmatic complications inherent in the Medicaid program itself. For example, the considerable across-county variation inherent in the New York State program leads to considerable problems in the creation of a State level report. As a consequence of these and other factors, in any fiscal year approximately six States do not file an annual report and in any month approximately two states do not file a monthly report. Historically, these missing reports have been estimated by using weighted linear extrapolation methods and aggregating data from other reports. It should be noted that on several occasions, information supplied by the States in subsequent years has been used to refine/correct previous missing years of data. Hence, data contained in this report may differ from those published previously.

Appendix 1

Medicare Carriers and Intermediaries

A. Blue Shield Carriers

Blue Cross and Blue Shield
of Alabama
450 Riverchase Parkway, East
Birmingham, Alabama 35298

Arkansas Blue Cross and
Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

California Physicians' Service
2 Northpoint Street
P. O. Box 7968-Rincon Annex
San Francisco, California 94120

Blue Cross and Blue Shield
of Colorado
700 Broadway
Denver, Colorado 80273

Blue Cross & Blue Shield
of Delaware, Inc.
201 West 14th Street
Wilmington, Delaware 19899

Medical Service of the
District of Columbia
550 - 12th Street, S.W.
Washington, D.C. 20024

Blue Shield of Florida, Inc.
P. O. Box 1798
Jacksonville, Florida 32231

Mutual Medical Insurance, Inc.
120 West Market Street
Indianapolis, Indiana 46204

Blue Shield of Iowa
Ruan Building
636 Grand Avenue
Des Moines, Iowa 50307

Blue Shield of Kansas, Inc.
1133 Topeka Boulevard
P. O. Box 239
Topeka, Kansas 66601

Blue Shield of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Shield of
Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield
of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield
of Minnesota
3535 Blue Cross Road
St. Paul, Minnesota 55765

Blue Shield of Kansas City
P. O. Box 169
Kansas City, Missouri 64141

Montana Physicians' Service
404 Fuller Avenue
P. O. Box 4310
Helena, Montana 59601

New Hampshire-Vermont
Health Service
Two Pillsbury Street
Concord, New Hampshire 03306

Blue Shield of
Western New York, Inc.
15 Chenango Street
Binghamton, New York 13901

Blue Cross and Blue Shield
of Greater New York
622 Third Avenue
New York, New York 10017

Blue Shield of North Dakota
4510 - 13th Avenue, S.W.
Fargo, North Dakota 58121

Pennsylvania Blue Shield
P. O. Box 65
Camp Hill, Pennsylvania 17011

Seguros de Servicio de Salud
de Puerto Rico, Inc.
GPO Box 3628
San Juan, Puerto Rico 00936

Blue Shield of Rhode Island
444 Westminister Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield
of South Carolina
Drawer F
Forest Acres Branch
Columbia, South Carolina 29219

South Dakota Medical
Service, Inc.
1601 West Madison
Sioux Falls, South Dakota 57104

Group Medical and
Surgical Service
P. O. Box 222147
Dallas, Texas 75222

Blue Shield of Utah
2455 Parley's Way
P. O. Box 30270
Salt Lake City, Utah 84125

Washington Physicians Service
2401 - 4th Avenue
4th & Battery Bldg. - 6th Floor
Seattle, Washington 98121

Wisconsin Physicians Service
Insurance Corporation
P. O. Box 9277
Madison, Wisconsin 53715

B. Commercial and Other Carriers

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, Connecticut 06152

E.D.S. Federal Corporation
7171 Forest Lane
Dallas, Texas 75230

The Equitable Life Assurance Society of the United States
1285 Avenue of the Americas
New York, New York 10019

General American Life Insurance Company
P. O. Box 505
St. Louis County, Missouri 63166

Group Health Incorporated
326 West 42nd Street
New York, New York 10036

Metropolitan Life Insurance Company
One Madison Avenue
New York, New York 10010

Mutual of Omaha Insurance Company
P. O. Box 456
Downtown Station
Omaha, Nebraska 68101

Mutual of Omaha Insurance Company
P. O. Box 456
Downtown Station
Omaha, Nebraska 68101

Nationwide Mutual Insurance Company
P. O. Box 1625
Columbus, Ohio 43216

Occidental Life Insurance Company of California
P. O. Box 54905
Terminal Annex
12th at Hill Street
Los Angeles, California 90054

Pan-American Life Insurance Company
P. O. Box 60450
New Orleans, Louisiana 70160

The Prudential Insurance Company of America
Drawer 471
Millville, New Jersey 08332

The Travelers Insurance Company
One Tower Square
Hartford, Connecticut 06115

C. State Agency

Department of Institutions, Social and Rehabilitative Services
P. O. Box 2532
State Capitol Station
Oklahoma City, Oklahoma 73125

D. Blue Cross Intermediaries

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway, East
Birmingham, Alabama 35298

Blue Cross and Blue Shield of Arizona, Inc.
321 West Indian School Road
P. O. Box 13466
Phoenix, Arizona 85002

Arkansas Blue Cross and Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

Blue Cross of Southern California
P. O. Box 70000
Van Nuys, California 91470

Blue Cross of Northern California
1950 Franklin Street
Oakland, California 94659

Blue Cross and Blue Shield of Colorado
700 Broadway
Denver, Colorado 80273

Blue Cross and Blue Shield of Connecticut, Inc.
370 Bassett Road
North Haven, Connecticut 06473

Blue Cross and Blue Shield of Delaware, Incorporated
201 West 14th Street
Wilmington, Delaware 19899

Group Hospitalization, Inc.
550 - 12th Street, S.W.
Washington, D.C. 20024

Blue Cross of Florida, Inc.
P. O. Box 1798
Jacksonville, Florida 32201

Blue Cross and Blue Shield of Georgia/Atlanta, Inc.
3348 Peachtree Road, N.E.
P. O. Box 4445
Atlanta, Georgia 30302

D. Blue Cross Intermediaries (Continued)

Blue Cross of
Georgia/Columbus, Inc.
2357 Warm Springs Road
P. O. Box 7368
Columbus, Georgia 31908

Blue Cross of Idaho
Health Service, Inc.
1501 Federal Way
P. O. Box 7408
Boise, Idaho 83707

Health Care Service
Corporation
233 North Michigan Avenue
Chicago, Illinois 60601

Mutual Hospital
Insurance, Inc.
120 West Market Street
Indianapolis, Indiana 46204

Blue Cross of Iowa
Ruan Building
636 Grand Avenue
Des Moines, Iowa 50307

Blue Cross of Western Iowa
and South Dakota
Third and Pierce Streets
Sioux City, Iowa 51102

Blue Cross of Kansas, Inc.
1133 Topeka Boulevard
P. O. Box 239
Topeka, Kansas 66601

Blue Cross and Blue Shield
of Kentucky, Inc.
9901 Linn Station Road
Louisville, Kentucky 40223

Louisiana Health Service
& Indemnity Company
P. O. Box 15699
Baton Rouge, Louisiana 70895

Associated Hospital Service
of Maine
110 Free Street
Portland, Maine 04101

Blue Cross of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Cross of
Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield
of Michigan
600 Lafayette East
Detroit, Michigan 48266

Blue Cross and Blue Shield
of Minnesota
3535 Blue Cross Road
St. Paul, Minnesota 55765

Blue Cross & Blue Shield
of Mississippi, Inc.
P. O. Box 1043
Jackson, Mississippi 39205

Blue Cross of Kansas City
P. O. Box 169
Kansas City, Missouri 64141

Blue Cross Hospital
Service, Inc. of Missouri
444 Forest Park
St. Louis, Missouri 63108

Blue Cross of Montana
3360 - 10th Avenue, South
P. O. Box 5017
Great Falls, Montana 59403

Blue Cross and Blue Shield
of Nebraska
P. O. Box 3248
Main Post Office Station
Omaha, Nebraska 68103

New Hampshire-Vermont
Health Service
Two Pillsbury Street
Concord, New Hampshire 03306

Hospital Service Plan
of New Jersey
33 Washington Street
Newark, New Jersey 07102

New Mexico Blue Cross
& Blue Shield, Inc.
12800 Indiana School Road, N.E.
Albuquerque, New Mexico 87112

New York Blue Cross Part A
P. O. Box 4846
Syracuse, New York 13212

Blue Cross and Blue Shield
of North Carolina
P. O. Box 2291
Durham, North Carolina 27702

Blue Cross of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121

Hospital Care Corporation
1351 William Howard Taft Road
Cincinnati, Ohio 45206

Blue Cross of Northeast Ohio
2066 East Ninth Street
Cleveland, Ohio 44115

Blue Cross of Central Ohio
255 East Main
P. O. Box 16526
Columbia, Ohio 43656

Blue Cross and Blue Shield
of Oklahoma
1215 South Boulder Avenue
Tulsa, Oklahoma 74119

Northwest Hospital Service
100 S.W. Market Street
P. O. Box 1217
Portland, Oregon 97201

Hospital Service Plan
of the Lehigh Valley
1221 Hamilton Street
Allentown, Pennsylvania 18102

Capital Blue Cross
100 Pine Street
Harrisburg, Pennsylvania 17101

Blue Cross of Greater
Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Blue Cross of Western
Pennsylvania
One Smithfield Street
Pittsburgh, Pennsylvania 15222

Hospital Service Association
of Northeastern Pennsylvania
Blue Cross Building
70 North Main Street
Wilkes Barre, Pennsylvania 18711

Blue Cross of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

D. Blue Cross Intermediaries (Continued)

Blue Cross and Blue Shield
of South Carolina
Drawer F
Forest Acres Branch
Columbia, South Carolina 29219

Blue Cross and Blue Shield
of Tennessee
Blue Cross Building
Chattanooga, Tennessee 37402

Memphis Hospital Service
and Surgical Association, Inc.
P. O. Box 98
Memphis, Tennessee 38101

Group Hospital Service, Inc.
P. O. Box 222146
Dallas, Texas 75222

Blue Cross of Utah
2455 Parley's Way
P. O. Box 30270
Salt Lake City, Utah 84125

Blue Cross of Virginia
2015 Staples Mill Road
P. O. Box 27401
Richmond, Virginia 23279

Blue Cross of Southwestern
Virginia
P. O. Box 13047
3959 Electric Road
Roanoke, Virginia 24045

Blue Cross of Washington
and Alaska, Inc.
15700 Dayton Avenue, North
P. O. Box 327
Seattle, Washington 98111

Blue Cross Hospital
Service, Inc.
P. O. Box 1353
Commerce Square
Charleston, West Virginia 25352

Parkersburg Hospital
Service, Inc.
P. O. Box 1948
Parkersburg, West Virginia 26101

West Virginia Hospital
Service, Inc.
20th and Chapline Streets
Wheeling, West Virginia 26003

Associated Hospital Service, Inc.
401 West Michigan Street
P. O. Box 2025
Milwaukee, Wisconsin 53203

Blue Cross Blue Shield
of Wyoming
4000 House Avenue
P. O. Box 2266
Cheyenne, Wyoming 82001

E. Other Intermediaries

Blue Cross Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156

Cooperative de Seguros de
Vida Puerto Rico
P. O. Box 3428 GPO
San Juan, Puerto Rico 00936

Hawaii Medical Service
Association
1594 Kapiolani Boulevard
P. O. Box 860
Honolulu, Hawaii 96808

Kaiser Foundation Health
Plan, Inc.
1956 Webster Street
Room 310-A
Oakland, California 94612

Mutual of Omaha Insurance
Company
P. O. Box 456
Downtown Station
Omaha, Nebraska 68101

Nationwide Mutual
Insurance Company
P. O. Box 1625
Columbus, Ohio 43216

The Prudential Insurance
Company of America
Drawer 471
Millville, New Jersey 08332

The Travelers Insurance
Company
One Tower Square
Hartford, Connecticut 06115

Appendix 2

Medicaid Agencies and Fiscal Agents

A. Single State Agencies and State Medical Assistance Units

Alabama (region IV):
Single State Agency and Medical Assistance Unit
Medical Services Administration
2500 Fairlane Drive
Montgomery, Alabama 36130
205 277-2710

Alaska (region X):
Single State Agency
Department of Health and Social Services
Pouch H-01
Juneau, Alaska 99811
907 465-3030

Medical Assistant Unit
Division of Public Assistance
Department of Health and Social Services
Pouch H-07
Juneau, Alaska 99811
907 465-3355

Arkansas (region VI):
Single State Agency:
Department of Human Services
Seventh and Main Donaghey Building, Room 1428
Little Rock, Arkansas 72201
501 371-1001

Medical Assistance Unit:
Office of Medical Services
Division of Social Services
Department of Human Services
P.O. Box 1437
Little Rock, Arkansas 72203
501 371-1806

California (region IX):
Single State Agency
Department of Health Services
714 P Street-Room 1253
Sacramento, California 95814
916 445-1248

Medical Assistance Unit:
Assistant Director
State Dept. of Health Services
714 P Street
Sacramento, California 95814
916 445-1351

Colorado (region VIII):
Single State Agency:
Department of Social Services
1575 Sherman Street
Denver, Colorado 80203
303 866-3041

Medical Assistance Unit:
Division of Medical Assistance
Department of Social Services
1575 Sherman Street
Denver, Colorado 80203
303 866-3031

Connecticut (region I):
Single State Agency:
Dept. of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566-2008

Medical Assistance Unit:
Medical Care Administration
Dept. of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566-4120

Delaware (region III):
Single State Agency:
Department of Health and Social Services
Delaware State Hospital
New Castle, Delaware 19720
302 421-6705

Medical Assistance Unit:
Medical Assistance Services
Department of Health and Social Services
Wilmington, Delaware 19720
302 421-6361

District of Columbia (region III):
Single State Agency:
Department of Human Services
Presidential Building-Room 407
415 12th Street, N.W.
Washington, D.C. 20004
202 727-0310

Medical Assistance Unit:
Medical Services Division
614 H Street, N.W.-Room 708
Washington, D.C. 20001
202 727-0735

Florida (region IV):
Single State Agency:
Department of Health and Rehabilitative Services
1323 Winewood Boulevard
Tallahassee, Florida 32301
904 488-7721

Medical Assistance Unit:
Social & Economic Services
Department of Health and Rehabilitative Services
1323 Winewood Boulevard
Tallahassee, Florida 32301
904 488-5461

Georgia (region IV):
Single State Agency:
Georgia Department of Medical Assistance
1010 West Peachtree St., N.W.
Atlanta, Georgia 30309
404 894-4911

Medical Assistance Unit:
Department of Medical Assistance
1010 West Peachtree St., N.W.
Atlanta, Georgia 30309
404 894-4911

Guam (region IX):
Single State Agency:
Department of Public Health and Social Services
P.O. Box 2816
Agana, Guam 96910
Overseas Operator: 734-9901

Medical Assistance Unit:
Medical Care Service
Department of Public Health and Social Services
P.O. Box 2719
Agana, Guam 96910
Overseas Operator: 734-9901

Hawaii (region IX):
Single State Agency:
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-6260

Medical Assistance Unit:
Medical Care Administration
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-6584

Idaho (region X):
Single State Agency:
Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208 334-4322

Medical Assistance Unit:
Medical Assistance Section
Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208 334-4323

Illinois (region V):
Single State Agency:
Illinois Dept. of Public Aid
316 South Second Street
Springfield, Illinois 62762
217 782-6716

Medical Assistance Unit:
Division of Medical Program Services
931 E. Washington Street
Springfield, Illinois 62763
217 782-0506

Indiana (region V):
Single State Agency:
Indiana Dept. of Public Welfare
State Office Building
100 North Senate Avenue-Room 701
Indianapolis, Indiana 46204
317 232-4705

Medical Assistance Unit:
Assistant Administrator-Medicaid
State Dept. of Public Welfare
100 North Senate Avenue-Room 701
Indianapolis, Indiana 46204
317 633-5582

Iowa (region VII):
Single State Agency:
Department of Social Services
Hoover State Office Building, 5th Fl.
Des Moines, Iowa 50319
515 281-5452

Medical Assistance Unit:
Medical Services Section
Department of Social Services
Hoover State Office Bldg.-5th Fl.
Des Moines, Iowa 50319
515 281-5452

Kansas (region VII):
Single State Agency:
Department of Social and Rehabilitation Service
State Office Building
Topeka, Kansas 66612
913 296-3271

Medical Assistance Unit:
Division of Medical Programs
Department of Social and Rehabilitation Service
State Office Building
Topeka, Kansas 66612
913 296-3981

Kentucky (region IV):
Single State Agency:
Department of Human Resources
DHR Building
275 East Main Street
Frankfort, Kentucky 40601
502 564-7130

Medical Assistance Unit:
Division for Medical Assistance
Department of Human Resources
Frankfort, Kentucky 40601
502 564-4321

Louisiana (region VI):
Single State Agency:
Louisiana Department of Health and Human Resources
P.O. Box 3776
Baton Rouge, Louisiana 70821
504 342-6711

Medical Assistance Unit:
Medical Assistance Program Administration
Office of Family Security
P.O. Box 44065
Baton Rouge, Louisiana 70804
504 342-3891

Maine (region I):
Single State Agency:
Department of Human Services
Statehouse
Augusta, Maine 04333
207 289-2736

Medical Assistance Unit:
Bureau of Medical Services
Department of Human Services
Statehouse
Augusta, Maine 04333
207 289-3846

Maryland (region III):
Single State Agency:
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
301 383-2600

Medical Assistance Unit:
Medical Programs
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
301 383-6327

Massachusetts (region I):
Single State Agency:
Department of Public Welfare
600 Washington Street
Boston, Massachusetts 02111
617 727-6190

Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5580

Medical Assistance Unit:
Medical Assistance
Department of Public Welfare
600 Washington Street
Boston, Massachusetts 02111
617 727-6095/3907

Medical Assistance
Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5590

Michigan (region V):
Single State Agency:
Michigan Department of Social Services
Commerce Center Building
P.O. Box 30037
Lansing, Michigan 48909
517 373-2000

Medical Assistance Unit:
Medical Services Administration
Department of Social Services
921 West Holmes Road
P.O. Box 30037
Lansing, Michigan 48909
517 373-8168

Minnesota (region V):
Single State Agency:
Department of Public Welfare
Centennial Office Building
658 Cedar Street
Saint Paul, Minnesota 55155
612 296-2701

Medical Assistance Unit:
Medical Assistance Program
Bureau of Income Maintenance
Department of Public Welfare
690 North Robert Street—
P.O. Box 43170
Saint Paul, Minnesota 55164

Mississippi (region IV):
Single State Agency and Medical Assistance Unit:
Mississippi Medicaid Commission
4785 I-55 North
P.O. Box 16786
Jackson, Mississippi 39206
601 354-7464

Missouri (region VII):
Single State Agency:
Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65101
314 751-4815

Medical Assistance Unit:
Division of Family Services
Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65101
314 751-2500

Montana (region VIII):
Single State Agency:
Department of Social and Rehabilitation Services
P.O. Box 4210
Helena, Montana 59601
406 449-5622

Medical Assistance Unit:
Medical Assistance Bureau
Economic Assistance Division
Department of Social and Rehabilitation Services
P.O. Box 4210
Helena, Montana 59601
406 449-3952

Nebraska (region VII):
Single State Agency
Department of Public Welfare
301 Centennial Mall South
5th Floor
Lincoln, Nebraksa 68509
402 471-3121

Medical Assistance Unit:
Medical Services Division
Department of Public Welfare
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
402 471-3121

Nevada (region IX):
Single State Agency:
Department of Human Resources
Kinkead Building-Capital Complex
505 East King Street
Carson City, Nevada 89710
702 885-4730

Medical Assistance Unit:
Medical Care Section (Title XIX)
Welfare Division
Department of Human Resources
251 Jeanell Drive
Capitol Complex
Carson City, Nevada 89710
702 885-4775

New Hampshire (region I):
Single State Agency:
Department of Health and Welfare Services
Hazen Drive
Concord, New Hampshire 03301
603 271-4331

Medical Assistance Unit:
Office of Medical Services
Hazen Drive
Concord, New Hampshire 03301
603 271-3706

New Jersey (region II):
Single State Agency:
Department of Human Services
Capitol Place One
Trenton, New Jersey 08625
609 292-3717

Medical Assistance Unit:
Division of Medical Assistance and Health Services
Department of Human Services
324 East State Street
Trenton, New Jersey 08625
609 292-7244

New Mexico (region VI):
Single State Agency:
Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503
505 827-2371

Medical Assistance Unit:
Medical Assistance Bureau
Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503
505 827-5551

New York (region II):
Single State Agency:
State Dept. of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518 474-9475

Medical Assistance Unit:
Division of Medical Assistance
State Dept. of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518 474-9132

North Carolina (region IV):
Single State Agency:
Department of Human Resources
325 North Salisbury Street
Raleigh, North Carolina 27611
919 733-4534

Medical Assistance Unit:
Division of Medical Assistance
Department of Human Resources
336 Fayetteville Street Mall
Raleigh, North Carolina 27601
919 733-2060

North Dakota (region VIII):
Single State Agency:
Social Service Board of North Dakota
State Capitol Building
Bismarck, North Dakota 58505
701 224-2310

Medical Assistance Unit:
Medical Service
Social Service Board of North Dakota
State Capitol Building
Bismarck, North Dakota 58505
701 224-2321

Ohio (region V):
Single State Agency:
Department of Public Welfare
30 East Broad Street, 32nd Floor
Columbus, Ohio 43215
614 466-6282

Medical Assistance Unit:
Division of Medical Assistance
Department of Public Welfare
30 East Broad Street, 31st Floor
Columbus, Ohio 43215
614 466-2365

Oklahoma (region VI):
Single State Agency:
Department of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 521-3646

Medical Assistance Unit:
Medical Units
Department of Institutions
Social and Rehabilitative Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 521-3801

Oregon (region X):
Single State Agency:
Department of Human Resources
318 Public Service Building
Salem, Oregon 97310
503 378-3034

Medical Assistance Unit:
Adult and Family Services Division
Department of Human Resources
203 Public Service Building
Salem, Oregon 97310
503 378-2263

Pennsylvania (region III):
Single State Agency:
State Department of Public Welfare
Health and Welfare Building
Harrisburg, Pennsylvania 17120
717 787-2600/3600

Medical Assistance Unit:
Office of Medical Assistance
State Department of Public Welfare
7th and Forester Streets
Harrisburg, Pennsylvania 17120
717 787-1174

Puerto Rico (region II):
Single State Agency:
Department of Health
P.O. Box 9342
Santurce, Puerto Rico 00908
809 751-8259

Medical Assistance Unit:
Health Economy Office
Department of Health
P.O. Box 10037
Caparra Heights Station
Rio Piedras, Puerto Rico 00922
809 765-9941

Rhode Island (region I):
Single State Agency:
Department of Social and Rehabilitative Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-2121

Medical Assistance Unit:
Division of Medicaid Services
Department of Social and Rehabilitative Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-2172

South Carolina (region IV):
Single State Agency:
State Department of Social Services
P.O. Box 1520
Columbia, South Carolina 29202
803 758-3244

Medical Assistance Unit:
Health Care Financing
State Department of Social Services
P.O. Box 1520
Columbia, South Carolina 29202
803 758-8182

South Dakota (region VIII):
Single State Agency:
Department of Social Services
Kneip Building
Pierre, South Dakota 57501
605 773-3165

Medical Assistance Unit:
Office of Medical Services
Department of Social Services
Kneip Building
Pierre, South Dakota 57501
605 773-3495
State Office Building
Pierre, South Dakota 57501
605 224-3495

Tennessee (region IV):
Single State Agency:
Department of Public Health
344 Cordell Hull Building
Nashville, Tennessee 37219
615 741-3111

Medical Assistance Unit:
Bureau of Medicaid Administration and Coordination
Department of Public Health
283 Plus Park Boulevard
Nashville, Tennessee 37219
615 741-6345

Texas (region VI):
Single State Agency:
Department of Human Resources
P.O. Box 2960
Austin, Texas 78769
512 441-3355

Medical Assistance Unit:
Deputy Commissioner for Medical Programs
John H. Reagan Building
Austin, Texas 78701
512 475-3542

Utah (region VIII):
Single State Agency:
Utah State Department of Health
150 West North Temple, Rm. 270
Salt Lake City, Utah 84110
801 533-6111

Medical Assistance Unit:
Division of Health Care Financing and Standards
Utah State Department of Health
P.O. Box 2500
Salt Lake City, Utah 84110
801 533-5038

Vermont (region I):
Single State Agency:
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05676
802 241-2220

Medical Assistance Unit:
Division of Medical Care
Department of Social Welfare
State Office Building
Montpelier, Vermont 05602
802 241-2800

Virgin Island (region II):
Single State Agency:
Department of Health
P.O. Box 7309
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 774-0117

Medical Assistance Unit:
Bureau of Health Insurance and Medical Assistance
Department of Health
Franklin Building
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 774-4624

Virginia (region III):
Single State Agency:
State Department of Health
109 Governor Street
Richmond, Virginia 23219
804 786-3561

Medical Assistance Unit:
Medical Assistance Program
State Department of Health
109 Governor Street
Richmond, Virginia 23219
804 786-7933

Washington (region X):
Single State Agency:
Division of Medical Assistance
Department of Social and Health Services
Mail Stop LK-11
Olympia, Washington 98504
206 753-1777

Medical Assistance Unit:
Division of Medical Assistance
Department of Social and Health Services
Mail Stop LK-11
Olympia, Washington 98504
206 753-1777

West Virginia (region III):
Single State Agency:
Office of Assistant Commissioner of Medical Services
1900 Washington Street, East
Charleston, West Virginia 25305
304 348-2400

Medical Assistance Unit:
Division of Medical Care
Department of Welfare
1900 Washington Street, East
Charleston, West Virginia 25305
304 348-8900

Wisconsin (region V):
Single State Agency:
Department of Health and Social Services
One West Wilson Street-Room 663
Madison, Wisconsin 53702
608 266-3681

Medical Assistance Unit:
Bureau of Health Financing
Division of Health
Department of Health and Social Services
One West Wilson Street-Room 325
Madison, Wisconsin 53702
608 266-2522

Wyoming (region VIII):
Single State Agency:
Department of Health and Social Services
317 Hathaway Building
Cheyenne, Wyoming 82002
307 777-7656

Medical Assistance Unit:
Medical Assistance Services
Division of Health and Social Services
Department of Health and Social Services
417 Hathaway Building
Cheyenne, Wyoming 82002
307 777-7531

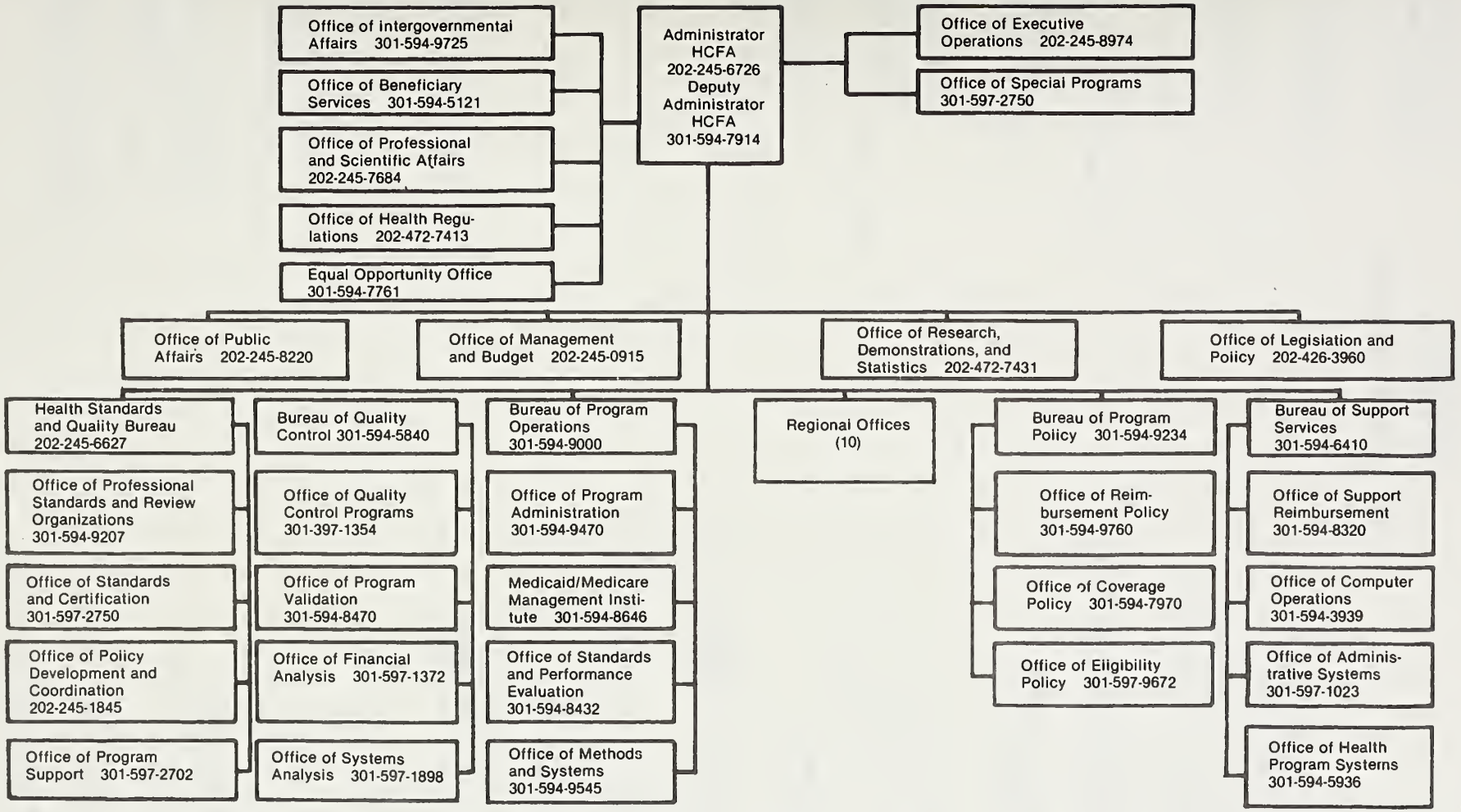
B. Medicaid Fiscal Agents and Health Insuring Agencies

Jurisdiction	Fiscal Agent(s) or Health Insuring Agency	Types of Claims Handled
Alabama	Alacaid	All services.
Alaska	Delta Dental Plan of Alaska Incorporated	Dental (EPSDT only).
	Computer Science Corporation	Physician, Inpatient and Outpatient billing.
Arkansas	Arkansas Blue Cross/Blue Shield	All services except SNFs and ICFs.
California	Computer Science Corporation	All institutional claims except for three northern counties.
	California Blue Shield	All non-institutional claims except dental.
	Redwood Health Foundation	All services except dental for three northern counties of Lake, Sonoma, and Mendocino.
	California Dental Services Association	Dental.
Colorado	Colorado Blue Cross/Blue Shield	All services.
Connecticut	Pilgrim Health Application, Inc.	Drugs.
Delaware	The Computer Company	All services except transportation and vendor payments to State institutions.
District of Columbia	No fiscal agent	
Florida	Systems Development Corporation	All services including payments of Parts A and B deductible and coinsurance.
Georgia	No fiscal agent	
Guam	No fiscal agent	
Hawaii	Hawaii Medical Services Administration	All services.
Idaho	Electronic Data Systems Federal Corp.	All services.
Illinois	No fiscal agent	
Indiana	Indiana Blue Cross/Blue Shield	All services.
Iowa	Iowa Blue Cross/Blue Shield	All services except ICF and ICF-MR.
	System Development Corporation	ICF and ICF-MR services.

Jurisdiction	Fiscal Agent(s) or Health Insuring Agency	Types of Claims Handled
Kansas	Electronic Data Systems Federal Corp.	All services except ICF and SNFs; also handle Medicare SNF crossover claims.
Kentucky	No fiscal agent	
Louisiana	The Computer Company	All services.
Maine	Health Systems Institute	Drugs, rural health.
Maryland	No fiscal agent	
Massachusetts	Massachusetts Blue Cross/Blue Shield	All services.
	Pilgrim Health Applications, Inc.	Drugs, dental, ambulance, labs, durable medical equipment, clinics, private duty nurses, and medical services for individuals over 65 years of age.
Michigan	No fiscal agent	
Minnesota	No fiscal agent	
Mississippi	Mississippi Blue Cross/Blue Shield	All services.
Missouri	Electronic Data Systems Federal Corp.	All services.
Montana	Dikewood Corporation	All services.
Nebraska	No fiscal agent	
Nevada	Nevada Blue Shield	Data entry and provider relations.
New Hampshire	No fiscal agent	
New Jersey	New Jersey Blue Cross	Inpatient and outpatient hospital and drugs.
	Prudential Insurance Company	All services, including some hospitals, except SNFs, ICFs, and institutions for tuberculosis and mental disease.
New Mexico	Electronic Data Systems Federal Corp.	All services.
New York	The Bradford National Corporation	All services.
North Carolina	Electronic Data Systems Federal Corp.	All services.
North Dakota	No fiscal agent	
Ohio	No fiscal agent	
Oklahoma	No fiscal agent	

Jurisdiction	Fiscal Agent(s) or Health Insuring Agency	Types of Claims Handled
Oregon	No fiscal agent	
Pennsylvania	Capital Blue Cross	Drugs, medical supplies, equipment and prosthetic devices.
	Inter-County Hospitalization Plan, Inc.	Inpatient hospital claims for the Philadelphia metropolitan area.
	Pennsylvania Blue Cross	All inpatient hospital claims except the Philadelphia metropolitan area.
	Pennsylvania Blue Shield	Physician inpatient care and emergency room services.
Puerto Rico	No fiscal agent	
Rhode Island	No fiscal agent	
South Carolina	No fiscal agent	
South Dakota	No fiscal agent	
Tennessee	Electronic Data Systems Federal Corp.	All services including payment of Parts A and B coinsurance and deductible.
Texas	National Heritage Insurance Company	All services except drugs, dental, hearing aids, and SNFs.
Utah	Delta Dental Corporation	Dental.
Vermont	New Hampshire-Vermont Health Services	All services except SNFs and ICFs.
Virgin Islands	No fiscal agent	
Virginia	The Computer Company	All services.
Washington	Electronic Data Systems Federal Corp.	All services.
West Virginia	No Fiscal Agent	All services.
Wisconsin	Electronic Data Systems Federal Corp.	All services.
Wyoming	Wyoming Dental Services, Inc.	Dental (EPSDT only).

FIGURE A.1
Health Care Financing Administration
Organization Chart, 1981



APPENDIX 3

Where to Call for Information

A. Medicare

Assignment Of Medicare Claims
Bureau of Program Policy — (301) 594-9324

Beneficiary Assistance On Claims And Entitlement
Office of Methods and Systems, BPO — (301) 594-9545

Beneficiary Information
Office of Beneficiary Services (Woodlawn) — (301) 594-8131
Office of Beneficiary Services (D.C.) — (202) 472-5240

Benefits Appeal Procedures
Office of Standards and Performance Evaluation, BPO — (301) 594-8431

Benefits Information
Bureau of Program Policy — (301) 594-9324

Complaints: Beneficiaries
Office of Beneficiary Services — (301) 594-8131

Complaints: General
Office of Administrator — (202) 245-8502
Office of Public Affairs — (202) 245-8220

Conditions Of Provider Participation
Office of Standards and Certification, HSQB — (301) 597-2750

Cost Estimates
Division of Medicare Cost Estimates, ORDS — (301) 594-2826

Deductibles: Explanation Of Beneficiary Liability
Bureau of Program Policy — (301) 594-9324

Directory Of Medical Facilities
Health Standards Quality Bureau
Division Field Operations, HSQB — (301) 594-7940

Enrollment Policy
Bureau of Program Policy — (301) 594-9324

Entitlement
Bureau of Program Policy — (301) 594-9324

Fraud, Abuse And Waste Allegation Or Complaints
Bureau of Quality Control
Field Operations Branch
Division of Validation Planning and Support, BQC — (301) 594-2077

Physician Provider Data
Analytical Studies Branch, OR, ORDS — (301) 597-1460

Prevailing Charges Directory
Office of Program Administration, BPO — (301) 594-9470

Professional Standards Review Organization (PSRO)
Office of Professional Standards Review Organization, HSQB — (301) 594-9207

Public Information
Office of Public Affairs (D.C.) — (202) 245-0923
Office of Public Affairs (Woodlawn) — (301) 594-9560

Publications: ORDS
ORDS Publications Office — (301) 597-2422

Pubication HCFA
Office of Public Information — (202) 245-0923

Quality Control
Office of Quality Control Programs, BQC — (301) 597-1348

Quality of Care Issues
Office of Professional Standards Review Organization, HSQB — (301) 594-9207

Reasonable Charges
Bureau of Program Policy — (301) 594-9324

Reimbursement Methods
Division of Reimbursement Studies, ORDS — (202) 245-6306

Reimbursement Policy
Bureau of Program Policy — (301) 594-9324

Regional Offices' Medicare Program Directors
Boston — (617) 223-6804
New York — (212) 264-2503
Philadelphia — (215) 596-6826
Atlanta — (404) 242-2994
Chicago — (312) 353-9840
Dallas — (214) 729-6418
Kansas City — (816) 758-3539
Denver — (303) 327-4024
San Francisco — (415) 556-6561
Seattle — (206) 399-0438

Research Results
Office of Research, Demonstrations, and Statistics, OR — (202) 245-6731

Service Coverage
Bureau of Program Policy — (301) 594-9324

State and Contractor Standards
Office of Standards and Performance Evaluations, BPO — (301) 594-8431

State Buy-Ins
Office of Methods and Systems,BPO — (301) 594-9545

Statistics: Beneficiaries
Division of Beneficiary Studies, ORDS — (301) 597-1430

Statistics: General
Division of Information Analysis, ORDS — (301) 594-6702

Statistics: Institutional Care
Institutional Studies Branch, ORDS — (202) 245-9162

Statistics: Medicare Program
Program Statistics Branch, ORDS — (301) 597-2424

Statistics: Non-Institutional Studies
Non-Institutional Studies Branch, ORDS — (301) 245-6306

Statistics: Professional Standards Review Organization
Division of Planning and Analysis, HSQB — (301) 594-9207

Fiscal Agents

Division of Procurement — (301) 594-8006
Office of Program Administration
Bureau of Program Operations
Health Care Financing Administration

Fraud and Abuse

Field Operations Branch — (301) 594-2077
Office of Program Validation
Bureau of Quality Control
Health Care Financing Administration

Medicaid Institutional Providers

Office of Statistics and
Data Management — (301) 594-0942
Office of Research, Demonstrations, and
Statistics
Health Care Financing Administration

Medicaid Management Information Systems

Office of Methods and Systems — (301) 594-8441
Bureau of Programs Operations
Health Care Financing Administration

Medicaid Quality Control System

Office of Quality Control Program — (301) 597-1354
Bureau of Quality Control
Health Care Financing Administration

Medicaid Statistics

Medicaid Program Data Branch — (301) 597-1411
Office of Research, Demonstrations,
and Statistics
Health Care Financing Administration

B. Medicaid

Abortion Data

Office of Standards and
Performance Evaluation
Bureau of Program Operations
Health Care Financing Administration
(301) 594-8784

Administration and Training Cost Data

Office of Financial Management Services
Office of Management and Budget
Health Care Financing Administration
(301) 594-8746

AFDC Eligibility, Need and Payment Standards

Office of Research and Statistics
Office of Policy
Social Security Administration
(202) 673-5610

Eligibility

Division of Medicaid Eligibility Policy
Office of Eligibility Policy
Bureau of Program Policy
Health Care Financing Administration
(301) 594-9050

EPSDT Data

Medicaid Program Data Branch
Office of Research, Demonstrations,
and Statistics
Health Care Financing Administration
(301) 597-1417

Expenditures

Medicaid Program Data Branch
Office of Research, Demonstrations,
and Statistics
Health Care Financing Administration
(301) 597-1417

Medically Needy Income Levels

State Plans Branch
Division of Agreements
Bureau of Program Operations
Health Care Financing Administration
(301) 594-7084

Recipients

Medicaid Program Data Branch
Office of Research, Demonstrations,
and Statistics
Health Care Financing Administration
(301) 597-1411

State and Local Administration and Training

Office of Financial Management Services
Office of Management and Budget
Health Care Financing Administration
(301) 594-8746

State Buy-In Data

Office of Statistics and Data Management
Office of Research, Demonstrations,
and Statistics
Health Care Financing Administration
(301) 594-6702

State Certification Cost Data

Financial Management Branch
Health Standards Quality Bureau
Health Care Financing Administration
(301) 597-7032

State Data

Medicaid Program Data Branch
Office of Research, Demonstrations, and Statistics
Health Care Financing Administration
(301) 597-1417

State Plans

State Plans Branch
Division of Agreements
Bureau of Program Operations
(301) 594-7084

Sterilization Data

Medicaid Program Data Branch
Office of Research, Demonstrations, and Statistics
Health Care Financing Administration
(301) 597-1430

Supplemental Security Income

Office of Research and Statistics
Office of Policy
Social Security Administration
(202) 673-5610

Third Party Liability

Office of Standards and Performance Evaluation
Bureau of Program Operations
Health Care Financing Administration
(301) 594-5726

Utilization

Medicaid Program Data Branch
Office of Research, Demonstration, and Statistics
Health Care Financing Administration
(301) 597-1411

APPENDIX 4

GLOSSARY OF MEDICARE AND MEDICAID TERMS

Aged: For purposes of enrollment under Medicare, individuals who are 65 years old or over are considered to be aged. The term is not relevant for the aged 65 and over basis of eligibility group in the Medicaid program.

Assignment: Under supplementary medical insurance, if the enrollee and the service provider both agree, the enrollee may assign his rights to benefits to the provider. When this assignment method is used, the provider agrees that his total charge for the covered service will be the reasonable charge approved by the carrier. The provider submits a claim to the carrier, and is reimbursed for the reasonable charge, minus the 20 percent coinsurance and any deductible which remains unmet. The provider may then charge the enrollee only for the coinsurance and any applicable deductible.

Automatic Enrollment: Retirement and survivors' insurance beneficiaries are automatically sent Medicare cards three months before the attainment of age 65; those entitled to disability-based benefits are automatically sent Medicare cards three months before the completion of 24 consecutive months of entitlement. These Medicare cards show entitlement to both hospital insurance and supplementary medical insurance; an enrollee wishing to decline SMI coverage must do so in writing no later than the month prior to the effective date of coverage.

Benefit Period: A benefit period is the time period used to limit Medicare benefits in the health insurance program. A benefit period begins the the first day an enrollee is furnished inpatient hospital or extended care services by a qualified provider, and ends when the enrollee has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. Although there are limits to covered benefits per benefit period, there is no limit to the number of benefit periods an enrollee can have. The enrollee must pay the hospital insurance deductible for each new benefit period.

Carrier: A carrier is an organization which has contracted with DHHS to process claims and perform other services under Medicare's supplementary medical insurance program.

Categorically Needy: Under Medicaid, categorically needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid and who meet financial eligibility requirements for AFDC, SSI, or an optional State supplement.

Coinsurance: Coinsurance is that portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not cover. Under HI, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through the 90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility care; from the 21st through the 100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under supplementary medical insurance, after the annual deductible has been met, Medicare will pay 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges is the coinsurance payable by the enrollee.

Copayment: Copayments are a type of cost-sharing under Medicaid whereby insured or covered persons pay a specified flat amount per unit of service or unit of time, and the insurer pays the rest of the cost.

Covered Services: Covered services are the specific services and supplies for which Medicare will provide reimbursement. Examples of some covered services are given in the Glossary under specific headings, such as Emergency Services, Skilled Nursing Facility Services, etc. Covered services under the Medicaid program consist of a combination of mandatory and optional services within each State.

Customary Charge: The charge a physician or supplier usually bills his patients for furnishing a particular service or supply is called the customary charge.

Deductible: Deductibles are the amounts payable by the enrollee for covered services before Medicare makes reimbursements. The hospital insurance deductible applies to each new benefit period, is determined each year by using a formula specified by law, and approximates the current cost of a one-day inpatient hospital stay. The supplementary medical insurance deductible is currently fixed by law at the first $60 of covered charges per calendar year.

Disabled: For purposes of enrollment under Medicare, individuals under age 65 who have been entitled for not less than 24 months to benefits under the Social Security Act or the railroad retirement system on the basis of disability are considered to be disabled.

Discharge: A discharge is a formal release from a hospital or a skilled nursing facility. Discharges include persons who died during their stay, or were transferred to another facility.

Early And Periodic Screening, Diagnosis, And Treatment (EPSDT): The EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

End-Stage Renal Disease (ESRD): For purposes of enrollment under Medicare, individuals who have chronic kidney disease requiring renal dialysis or kidney transplant are considered to have end-stage renal disease. To qualify for Medicare coverage, the individual must be fully or currently insured under social security or the railroad retirement system, or be the dependent of an insured person. Eligibility for Medicare coverage begins with the 3rd month after the month in which a course of renal dialysis begins. Coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility; or if a person receives a kidney transplant without starting or receiving dialysis.

Enrollment Period: A Medicare beneficiary may voluntarily enroll for supplementary medical insurance at any time; entitlement begins on the third calendar month following the month of enrollment.

Expenditure: Under Medicaid, expenditure refers to an amount paid out by a State agency for the covered medical expenses of eligible participants.

Family Planning Services: Family planning services are any medically approved means, including diagnosis, treatment, drugs, supplies and devices, and related counseling which are furnished or prescribed by or under the supervision of a physician for individuals of child-bearing age for purposes of enabling such individuals freely to determine the number or spacing of their children.

Federal Hospital Insurance Trust Fund: The Federal hospital insurance trust fund is a trust fund of the Treasury of the United States in which are deposited monies collected from taxes on annual earnings of employees, employers, and self-employed persons covered under social security, and other gifts and bequests to the fund. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the hospital insurance program.

Federal Supplementary Medical Insurance Trust Fund: The Federal supplementary medical insurance trust fund is a trust fund of the Treasury of the United States consisting of gifts and bequests made to the fund, and amounts deposited in or appropriated to the fund as provided by Title XVIII of the Social Security Act including premiums paid in by enrollees under SMI and contributions by the Federal government from general revenues. Disbursements from the fund are made for benefit payments and administrative expenses incurred by the SMI program.

Fiscal Agent: A fiscal agent is a contractor that processes or pays vendor claims on behalf of the Medicaid agency. Under Medicare, fiscal agents are called intermediaries (HI), and carriers (SMI).

General Hospital: A general hospital is a hospital maintained primarily for inpatient care of acute illness or injury, and for obstetrics.

Group Practice Prepayment Plan (GPPP): In general, members of group practice prepayment plans pay regular premiums to the plan. In return, the members receive the health services the plan provides, whenever needed, without additional charges. Many prepayment plans have made arrangements with Medicare to receive direct payments for services they furnish which are covered by SMI.

Health Insuring Organization: A health insuring organization is an entity that pays for medical services provided to recipients who pay a premium or subscription charge to the entity, which assumes an underwriting risk with regard to expenses for the services provided.

Health Maintenance Organization (HMO): Some group practice prepayment plans also provide many inpatient services, and therefore have contracts with Medicare as Health Maintenance Organizations which allows them to receive direct payment for services covered by hospital insurance and supplementary medical insurance.

Home Health Agency: A home health agency is a public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home, and which meets certain conditions designed to ensure the health and safety of the individuals who are furnished these services.

Home Health Services: Home health services are services and items furnished to an individual who is under the care of a physician by a home health agency, or by others under arrangements made by such agency. The services are furnished under a plan established and periodically reviewed by a physician. The services are provided on a visiting basis in an individual's home and include: part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services, medical supplies and appliances (other than drugs and biologicals); home health aide services; and services of interns and residents.

Hospital Insurance: Hospital insurance (also knows as Medicare Part A) is an insurance program providing basic protection against the costs of hospital and related post-hospital services for individuals who are age 65 or over and are eligible for retirement benefits under the social security or the railroad retirement systems, for individuals under age 65 who have been entitled for not less than 24 months to benefits under the social security or railroad retirement systems on the basis of disability, and for certain other individuals who are medically determined to have end-stage renal disease and are covered by the social security or railroad retirement systems.

Independent Laboratory: An independent laboratory is a laboratory certified to perform diagnostic tests independent of a physician's office or hospital and to receive reimbursements from Medicare.

Inpatient Hospital Services: Inpatient hospital services are items and services furnished to an inpatient of a hospital by the hospital, including bed and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Intermediary: An intermediary is an organization selected by providers of health care which has entered into an agreement with DHHS under Medicare's hospital insurance program to process claims and perform other functions.

Intermediate Care Facility: An intermediate care facility is an institution furnishing health-related care and services to individuals who do not require the degree of care provided by hospitals or skilled nursing facilities as defined under Title XIX (Medicaid) of the Social Security Act.

Laboratory And Radiological Services: Laboratory and radiological services are professional and technical laboratory and radiological services ordered by a licensed practitioner and provided in an office or similar facility (other than a hospital outpatient department or clinic) or by a qualified laboratory.

Lifetime Reserve: A Medicare hospital insurance enrollee has a non-renewable lifetime reserve of 60 days of inpatient hospital care to draw upon if the 90 covered days per benefit period are exhausted.

Long-Stay Hospital: A long-stay hospital is one in which the average patient stay is 30 days or more.

Medically Needy: Under Medicaid, medically needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid, and whose income resources are above the limits for eligibility as categorically needy (AFCD or SSI) but are within limits set under the Medicaid State plan.

Other Practitioners' Services: Other practitioners' services are health care services of licensed practitioners other than physicians and dentists.

Outpatient Hospital Services: Outpatient hospital services are services furnished to outpatients by a participating hospital for diagnosis or treatment of an illness or injury.

Outpatient Services: Outpatient services are medical and other services provided by a hospital or other qualified facility or supplier, such as a mental health clinic, rural health clinic, mobile X-ray unit, or free-standing dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, X-ray and other radiation therapy.

Persons Served: Under Medicare, a person served is a Medicare enrollee who uses a covered medical service, incurs expenses greater than the deductible amount, and for whom Medicare paid benefits.

Physicians' Services: Under Medicare and Medicaid, physicians' services are services provided by an individual licensed under State law to practice medicine or osteopathy. Services covered by hospital bills are not included.

Portable X-ray: A portable X-ray is a radiograph taken with portable equipment, usually in the patient's place of residence, under the general supervision of a physician.

Premium: A premium is a monthly fee paid by enrollees in Medicare. Hospital insurance enrollees who are social security or railroad retirement beneficiaries and who qualify for coverage through age or disbility are not required to pay premiums. Aged persons who are not eligible for automatic HI enrollment may pay a monthly premium to obtain HI coverage. supplementary medical insurance enrollees pay a monthly premium which is updated every July to reflect changes in program costs.

Premium Hospital Insurance: Those persons 65 years and older who are not automatically eligible for hospital insurance may obtain coverage by paying a monthly premium.

Prescribed Drugs: Prescribed drugs are drugs dispensed by a licensed pharmacist on the prescription of a practitioner licensed by law to administer such drugs, and drugs dispensed by a licensed practitioner to his own patients. This item does not include a practitioner's drug charges that are not separable from his other charges, or drugs covered by a hospital's bill.

Prevailing Charge: The prevailing charge is the charge that would cover 75 percent of the customary charges made for similar services in the same locality.

Professional Standards Review Organization (PSRO): A PSRO is a physician or other professional medical organization (consisting of physicians and other health professionals with independent admitting hospital privileges) that enters into an agreement with DHHS to assume the responsibility for the review of the quality and appropriateness of services covered by Medicare, Medicaid, and the Maternal and Child Health program. PSROs determine whether services are medically necessary, provided in accordance with professional standards, and, in the case of institutional services, rendered in the appropriate setting.

Psychiatric Hospital: A psychiatric hospital is an institution primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mental illness.

Railroad Retirement System: The railroad retirement system was mandated by the Railroad Retirement Act of 1937 to be a retirement system for railroad employees.

Reasonable Charge: In processing claims for SMI benefits, carriers use HCFA guidelines to establish the reasonable charge for services rendered. The reasonable charge is the lowest of: the actual charge billed by the physician or supplier; the charge the physician or supplier customarily bills his patients for the same service; and the prevailing charge which most physicians or suppliers in that locality bill for the same service. Increases in the physicians' prevailing charge levels are recognized only to the extent justified by an index reflecting changes in the costs of practice and in general earnings.

Reasonable Cost: In processing claims for HI benefits, intermediaries use HCFA guidelines to determine the reasonable cost incurred by the individual providers in furnishing covered services to enrollees. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs which are unnecessary in the efficient delivery of services covered by the insurance program.

Recipient: A recipient of Medicaid is an individual who has been determined to be eligible for Medicaid and who has used medical services covered under Medicaid.

Reimbursement: Under Medicare, the reimbursement amount refers to the dollar amount of medical expenses payable by the Medicare program. (For Medicaid, see Expenditures.)

Rural Health Clinic: A rural health clinic is an outpatient facility which is primarily engaged in furnishing physicians' and other medical and health services, which meets certain other requirements designed to ensure the health and safety of the individuals served by the clinic. The clinic must be located in an area that is not an urbanized area as defined by the Bureau of the Census and that is designated by the Secretary of DHHS either as an area with a shortage of personal health services, or as a health manpower shortage area, and has filed an agreement with the Secretary not to charge any individual or other person for items or services for which such individual is entitled to have payment made by Medicare, except for the amount of any deductible or coinsurance amount applicable.

Short-Stay Hospital: A short-stay hospital is one in which the average length of stay is less than 30 days. General and special hospitals are included in this category.

Skilled Nursing Facility (SNF): A skilled nursing facility is an institution which has in effect a transfer agreement with one or more participating hospitals, and which is primarily engaged in providing to inpatients skilled nursing care and restorative care services, and meets specific regulatory certification requirements.

Skilled Nursing Facility Services: SNF services are all services furnished to inpatients of, and billed for by, a formally certified skilled nursing facility that meets standards required by the Secretary of DHHS.

Spend-Down: Under the Medicaid program, spend-down refers to a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements.

State Buy-In: State buy-in is the term given to the process by which a State may provide SMI coverage for its needy eligible persons through an agreement with the Federal government under which the State pays the premiums for them.

State Plan: The Medicaid State plan is a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

Supplemental Security Income (SSI): SSI is a program of income support for low-income aged, blind, and disabled persons established by Title XVI of the Social Security Act.

Supplementary Medical Insurance (SMI): SMI (also known as Part B) is a voluntary insurance program which provides insurance benefits for physician and other medical services in accordance with the provisions of Title XVIII of the Social Security Act for aged and disabled individuals who elect to enroll under such program. The program is financed from premium payments by enrollees, together with contributions from funds appropriated by the Federal government.

Third-Party Liability: Under Medicaid, third-party liability exists if there is any entity (including other government programs or insurance) which is or may be liable to pay all or part of the medical cost or injury, disease, or disability of an applicant or recipient of Medicaid.

Vendor: A medical vendor is an institution, agency, organization, or individual practitioner which provides health or medical services.

APPENDIX 5

MEDICARE AND MEDICAID ACRONYMS

AABD	Aid to the Aged, Blind, and Disabled
AB	Aid to the Blind
ADP	Automatic Data Processing
AFDC	Aid to Families with Dependent Children
APTD	Aid to the Permanently and Totally Disabled
CCU	Coronary Care Unit
CFR	Code of Federal Regulations
CP	Claims Processing
DHHS	Department of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ESRD	End-Stage Renal Disease
FFP	Federal Financial Participation
GPPP	Group Practice Prepayment Plan
HCFA	Health Care Financing Administration
HHA	Home Health Agency
HI	Hospital Insurance
HMO	Health Maintenance Organization
ICF	Intermediate Care Facility
ICU	Intensive Care Unit
JCAH	Joint Commission on the Accreditation of Hospitals
MAC	Maximum Allowable Cost
MAO	Medical Assistance Only
MMIS	Medicaid Management Information System
MQC	Medicaid Quality Control
OAA	Old Age Assistance
OIG	Office of the Inspector General
PSRO	Professional Standards Review Organization
RRF	Railroad Retirement Fund
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
TPL	Third-Party Liability

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